Northern Inyo Hospital

March 21 2018 Regular Meeting

March 21 2018 Regular Meeting - March 21 2018 Regular Me

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

March 21, 2018 at 5:30 p.m.

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

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business

   A. Approval of NIHD Foundation Board member, Jane Thompson (*action item*).

   B. Quarterly Pillars of Excellence report (*action item*).

   C. Chief Operating Officer report (*information item*).

   D. Chief Human Resources Officer report (*information item*).

   E. Chief Nursing Officer report (*information item*).

   F. Chief Financial Officer report (*information item*).

   G. District Board Resolution 18-01, *Northern Inyo Health LLC* (*action item*).

   H. District Board Resolution 18-02, *Segregation of Restricted and Specific Funds* (*action item*).

   I. Chief Executive Officer report (*information item*).

   J. Northern Inyo Healthcare District Bylaws review (*action item*).

   K. CEO Contract Approval (*action item*).
4. Old Business

   A. Athena implementation update (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the February 21, 2018 regular meeting
6. Financial and Statistical reports for January 2018
7. 2013 CMS Survey Validation Monitoring
8. Policy and Procedure annual approvals

---

9. Chief of Staff Report; Richard Meredick, MD:

A. Policies/Procedures/Protocols/Order Sets (*action items*):

1. *Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)*
2. *Collection of Aerobic and Anaerobic Cultures*
3. *Emergency Care Policy for Emergency Department Physician Assistant – Standardized Procedure*
4. *General Policy for Emergency Department Physician Assistant – Standardized Procedure*
5. *Intimate Partner Abuses Guidelines, for Victims of*
6. *Intravenous to Oral Route of Administration Opioid Conversion Protocol – Inpatient Adult*
7. *Medication/Device Policy for Emergency Department Physician Assistant – Standardized Procedure*
8. *Multidrug Resistant Organism (MDRO) Control Plan*
9. *N95 Mask Fit Testing Using PortaCount Pro*
10. *Opening and Closing Nursing Departments*
11. *Standards of Care in the ICU*
12. *Warfarin Protocol – Inpatient Adult*

B. Annual Approvals (*action items*):

1. Utilization Review Critical Indicators
2. Pediatric Critical Indicators
3. Standardized Procedures and Protocols
    - *I. RN First Assistant*
    - *II. Medical Screening Examination of the Obstetrical Patient*
    - *III. CNM First Assist During Cesarean Sections*
    - *IV. Physician Assistant in the OR*

C. Medical Staff Advancement (*action item*):

1. Uttama Sharma, MD (*family medicine*) – Dr. Sharma has undergone 50+ chart reviews and direct supervision Thurs-Sat x 4 months by her proctor, Stacey Brown, MD since her appointment in August 2017. Dr. Brown is happy to report Dr. Sharma has completed her focused professional practice evaluation (FPPE) and is recommending her for advancement from Provisional Staff to full Active Staff at NIHD.

D. Medical Staff Appointments/Privileges (*action item*):

1. Michael H. Abdulian, MD (*Orthopedic Surgery*), Provisional Consulting Staff
2. David B. Huddleston, MD (*General Surgery*), Provisional Active Staff
3. Kristin Irmiter, MD (*Pediatrics*), Provisional Active Staff
4. Daniel Firer, MD (*Family Medicine, Emergency Department*), Provisional Active Staff
5. Sandra Althaus, MD (*Interventional Radiology*), Consulting Staff
6. Ryan Berecky, MD (*Neuroradiology*), Consulting Staff
7. Nicholas Carlevato, MD (*Interventional Radiology*), Consulting Staff
8. David Landis, MD (*Diagnostic Radiology*), Locum Tenens
9. Stephen Loos, MD (*Diagnostic Radiology*), Active Staff
10. Keith Shonnard, MD (*Interventional Radiology*), Consulting Staff
11. Gary Turner, MD (*Neuroradiology*), Consulting Staff

E. Telemedicine Staff Appointments/Privileges – credentialing by proxy (*action items*):

1. *As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions*:
    - Azadeh Majlessi, MD (*rheumatology*), Distant Site: Adventist Health (Glendale); Telemedicine Staff
    - Nilem Patel, MD (*endocrinology*), Distant Site: Adventist Health (Glendale), Telemedicine Staff

F. Temporary Locum Tenens Privileges (*action item*):

1. *The following physician has undergone the full credentialing process and has been recommended for temporary/locum tenens privileges for up to 60 days in 2018, unless extended and approved for good cause*:
    - Arsen Mkrtchyan, MD, Internal Medicine (*hospitalist*), Temporary/locum tenens (*up to 60 days in 2018*)

G. Additional Privileges – Allied Health Professionals (*action item*):

1. *The following Allied Health Professional has applied for privileges in the Emergency Department. In times of heavy patient volume, the ED physician on duty may call upon the applicant to assist with patient care. The applicant will be working under approved Standardized Protocols and will undergo an initial period of monitoring*:
    - Jennifer Figueroa, PA-C (*Emergency Department*), Allied Health Professional

H. Change in Staff Category (*action item*):

1. Edmund P. Pillsbury III, MD (*radiology*) – application for change in staff category from Consulting Staff to Active Staff

10. Reports from Board members (*information items*).
11. Adjournment to closed session to/for:

A. Conference with Labor Negotiators; Agency Designated Representative: Kevin Dale; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 3 matters pending (*pursuant to Government Code Section 54956.9*).

C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).

D. Discussion of a real estate negotiation (*pursuant to Government Code Section 54956.8*).

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

12. Return to open session and report of any action taken in closed session.
13. Adjournment

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

NORTHERN INYO HEALTHCARE DISTRICT

Hospital-Wide Pillars of Excellence: FY July 1, 2017-June 30, 2018

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. RHC- Overall score % Top Box	**73.0 Below Average[1]**	**85.0 Better Than Most**	**78.0 Below Average[1]**	**78.2 Below Average[1]**			**78.0 Below Average[1]**
b. Emergency Department-Overall score % Top Box	**71.7 Below Average[2]**	**85.0 Better Than Most**	**70.4 Below Average[2]**	**77.2 About Average[2]**			**72.8 Below Average[2]**
c. HCAHPS Perinatal- Overall score % Top Box	**75.4 Above Average[3]**	**85.0 Better Than Most**	**92.5 Best in Class[3]**	**43.9 Below Average[3]**			**70.4 About Average[3]**
d. HCAHPS MedSurg- Overall score % Top Box	**66.4 Below Average[4]**	**85.0 Better Than Most**	**67.3 Below Average[4]**	**56.0 Below Average[4]**			**62.4 Below Average[4]**
Note: Baseline was calculated on data from Q2, Q3 and Q4 due to transition to Press Ganey. 1. Peer Comparison = All PG Medical Practice Groups. 2. Peer Comparison= Hospitals with 10,000 or less visits/year. 3. Peer Comparison= Hospitals with 20-30 Beds. 4. Peer Comparison= Hospitals with 20-30 Beds.							
Quality							
1. Adverse Drug Events-Anticoagulants*	**1/22 (4.5%)**	**0**	**0/11 (0%)**	**0/6 (0%)**			**0/17 (0%)**
2. Surgical Site Infections*,[1]	**9/1420 (0.63%)**	**0**	**1/377 (0%)**	**0/379 (0%)**			**1/756 (0%)**
3. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*	**0/205 (0.0)**	**0**	**0/88 (0)**	**0/81 (0)**			**0/169 (0%)**
4. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*	**1/711 (0.14)**	**0**	**0/207 (0)**	**0/194 (0)**			**0/401 (0%)**
5. Ventilator Associated Events*	**0/23 (0%)**	**0**	**0/12 (0%)**	**0/6 (0%)**			**0/18 (0%)**
6. Falls With Injuries (Per 1000 Patient Days)*	**2/2454 (0.81)**	**0**	**4/813 (4.9)**	**0/894 (0)**			**4/1707 (0%)**
7. 30 Day Readmission Rate (Inpatient)*	**29/1168 (2.4%)**	**<15%**	**8/274 (2.9%)**	**2/264 (0.76%)**			**10/538 (1.8%)**
*Note: Baseline period for these metrics is FY 16-17. 1. SSI National average is about 2.0%. 2. Correction was made in denominator for this data.							
People							
1. Overall Turnover Rate, 3	**74/513 (14.42%)**	**<15%**	**5.70%**	**4.50%**			**9.72%**
a. Active			**429**	**426**			
b. Leave Of Absence			**18**	**20**			
c. Terminated			**27**	**21**			
2. Total Recordable Incident Rate (OSHA) per 100 employees-Modified**	**52/425 (12.24%)**	**0**	**12/447 (2.68%)**	**11/446 (2.47%)**			**23/446 (5.1%)**
Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio	**3.12**	**>2.0**	**2.45**	**2.28**			**2.36**
2. Days Cash on Hand-Short Term Sources	**78**	**>75**	**64.38**	**83.83**			**74.10**
3. Debt Service Coverage Ratio	**2.26**	**>1.5-2.0**	**2.6**	**2.73**			**2.66**
4. A/R Days (Inpatient & Outpatient)	**79**	**<60**	**79.2**	**82**			**80.6**

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

Important General Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero Patient Satisfaction/Patient Experience-For each department the Top Box Percentile Rank for the chosen Peer Comparison groups was used to classify the performance category based on the following cut points; 90-100 Best in Class (Blue), 75-89 Above Average (Green), 50-74 About Average (Yellow), ≤49 Below Average (Red). It is recommended that specific performance dimensions be further assessed by area leadership to identify specific opportunities for improvement.

Rev. 02/01/18

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, California
93514
(760) 873-5811 voice
(760) 872-2768 fax

March 6, 2018

Memo To: Board of Directors
Northern Inyo Healthcare District

From: John Tremble, CFO

Subject: Request to Change Accounting Practices for Funds

For the past decade the Restricted and Specific Purpose Funds have been both accounted for and held as stand alone funds of the District. Over the past four years, the number of funds (and separate bank accounts) has grown from eight to eleven. With the number of bank accounts, the annual banking transaction fees charged to the District has also grown from $35,527 in calendar year 2014 to $72,328 in calendar year 2017, more than 100%.

At the same time, the perpetual low interest rates credited on balances held by the bank for the District have only covered 10% of our costs. In analyzing the funds, two have had no activity since 2010 and others have had minimal transactions.

In order to reduce the cost of holding these funds, I recommend that Northern Inyo Healthcare District adopt a policy of holding Restricted and Specific Purpose Funds in book entry form only. Book entry accounting simply means a general bank or investment account has multiple general ledger accounts which make up its total balance. The accounting staff balances the balance per bank to the combined balances of all the Specific funds designated by the Board.

The adoption of this policy will result in the closing of five (5) bank accounts immediately and the elimination of $2,400 in annual fees and the generation of $16,800 annually in interest income with the balances of the funds invested in the LAIF account of the District.

As the District changes its processes and business activities, Accounting will strive to reduce the fees incurred in our banking transactions. A Board Resolution has been drafted for your consideration.

Northern Inyo Healthcare District

District Board Resolution 18-01

Whereas Northern Inyo Healthcare District desires to expand services beyond that of a local Critical Access Hospital and

Whereas the State of California recognizes the right of communities to organize into a “Healthcare District” and

Whereas an expansion of services and access is consistent with the needs of the communities served by Northern Inyo Healthcare District and

Whereas to provide such services and access a “Healthcare District” must have the proper legal structures to operate any such health care enterprise necessary to meet the needs of the communities it serves

The Board of Directors of Northern Inyo Healthcare District hereby authorizes the creation of a subsidiary of the District to be known as Northern Inyo Health, LLC

Now Therefore Be It Resolved that Northern Inyo Health, LLC shall be a registered entity of Northern Inyo Healthcare District with its own registration, and Entity Identification Number

Be It Further Resolved that the Board of Directors now instruct the Chief Officers of Northern Inyo Healthcare District to take any and all necessary steps to create Northern Inyo Health, LLC, register it with the appropriate State and Federal organizations and to establish the necessary books and records for the entity to be successful in its mission as established by the Board of Directors of Northern Inyo Healthcare District.

This Resolution is adopted March 21, 2018 by vote of the Board of Directors.

_____ _____

John Ungersma, MD, President Mary Mae Kilpatrick, Secretary

Northern Inyo Healthcare District

District Board Resolution 18-02

Whereas Northern Inyo Healthcare District operates a Critical Access Hospital and

Whereas the State of California recognizes the Healthcare District has the need to maintain funds in accounts in order to meet its Mission and

Whereas the Northern Inyo Healthcare District desires to accomplish its goals with a minimum of costs and maximum efficiency

The Board of Directors hereby Resolves to adapt Book Entry Accounting for the segregation of Restricted and Specific Funds as allowed by California law and the agreements previously executed by the Board of Directors

The Board Further Resolves that the Specific Purpose Funds of Medical Education of $75 and Equipment Fund of $26,726 are no longer necessary and Hereby considers the specific purpose of each fund satisfied

Be It Further Resolved that the Board of Directors now instructs the Chief Officers of Northern Inyo Healthcare District to take any and all necessary steps to adopt Book Entry Accounting for Northern Inyo Healthcare District and to change the banking and investment accounts as necessary to adopt this Resolution.

This Resolution is adopted March 21, 2018 by vote of the Board of Directors.

_____ _____

John Ungersma, MD, President Mary Mae Kilpatrick, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ADOPTED BY THE BOARD OF DIRECTORS

NORTHERN INYO HEALTHCARE DISTRICT

Preamble

Formatted: Centered

The Board of Directors shall perform its oversight of Northern Inyo Healthcare District activities with the highest ethical standards. It shall work to ensure that the District Mission, Vision and Values are at the center of decision-making. The Board of Directors shall work to ensure that all financial and personnel matters are handled with honesty and transparency to the extent possible. The Board of Directors shall work to ensure that District policies, procedures and training are consistent with this purpose in mind.

With all matters impacting employees, community and patients the Board shall strive to adhere to District Values and the highest ethical standards in its deliberations.

REVISED AND ADOPTED IN CONFORMANCE WITH DIVISION 23, SECTION 32000 ET SEQ. OF THE CALIFORNIA HEALTH AND SAFETY CODE ON FEBRUARY 25, 2015

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

TABLE OF CONTENTS

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE I

NAME, AUTHORITY AND OFFICES

Section 1. NAME

The name of this non-profit health care district organization shall be the Northern Inyo Healthcare District, hereinafter "the District".

Section 2. AUTHORITY

a) This District, having been established January 11, 1946, by vote of the residents of the District under the provisions of Division 23, Section 32000 et seq, of the Health and Safety Code of the State of California, otherwise known and referred to herein as "The Local Health Care District Law," and ever since said time having been operated thereunder, these bylaws are adopted in conformance therewith, and subject to the provisions thereof.

b) In the event of any conflict between these bylaws and "The Local Health Care District Law," the latter shall prevail. To the extent they are not in conflict with these bylaws, the proceedings of the District Board shall be guided by the most recent edition of Robert's Rules of Order.

Section 3. OFFICES

The principal office for the transaction of business of the District is hereby fixed within the boundaries of the District as determined by the Board of Directors.

Section 4. TITLE OF PROPERTY

The title to all property of the District shall be vested in the District, and the signature of the President and/or Secretary, or any officer designated by the Directors, as authorized at any meeting of the Directors, shall constitute the proper authority for the purchase or sale of property, or for the investment or other disposal of funds which are subject to the control of the District.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE II

PURPOSES AND SCOPE

Section 1. PURPOSES

The purposes of the Northern Inyo Healthcare District shall include, but not be limited to the following:

a) Within available resources, to provide facilities and health services for quality acute and continued care of the injured and ill, inducing health maintenance and education, regardless of sex, race, creed, sexual orientation, cultural or national origin.

b) To coordinate, wherever possible and feasible, the activities of the District with health agencies and other health facilities providing specialized as well as comprehensive care.

c) To conduct educational and research activities essential to the attainment of its purposes.

d) To do any and all other acts necessary to carry out the provisions of the Health Care District Act.

Section 2. SCOPE OF BYLAWS

a) These bylaws shall govern the Northern Inyo Healthcare District, its Board of Directors and its relationship to affiliated or subordinate organizations. The primary purpose of these bylaws is to provide rules for the self-governance of the District and the Board of Directors, to provide a structure for the Board of Directors to fulfill its functions and responsibilities with respect to an organized self-governing Medical Staff, and to provide a structure for Administration ~~of the~~ all licensed and unlicensed healthcare inpatient and outpatient facilities operated by the District ~~(specifically Northern Inyo Hospital, 1206 D and 1206 B clinics)~~.

b) The Board of Directors may delegate certain powers to the Authority of the Board's committees, the Medical Staff, and to other affiliated and subordinate organizations and groups governed by the District, such powers to be exercised in accordance with the respective bylaws or guidelines of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups are to be considered

residual powers vested in the Board of Directors of this District.

c) The Bylaws, Rules and Regulations of the Medical Staff and other affiliated and subordinate organizations and groups governed by the District, and any amendments to such bylaws, shall not be effective until the same are approved by the Board of Directors of the Northern Inyo Healthcare District. The provisions of these District bylaws shall be construed to be consistent with the Medical Staff s bylaws. Except that these Bylaws shall not conflict with the bylaws of the Medical Staff as approved by the Board of Directors, the Board of Directors may review these Bylaws and revise them as it deems appropriate.

Section 3. NOT FOR PROFIT STATUS

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits to any individual, under any guise whatsoever; nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. DISPOSITION –OF SURPLUS

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable District purposes or for improvements hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Act, or these bylaws. The Board of Directors may authorize the disposition of any surplus property of the District by any method determined appropriate by the Board.

Section 5. INDEMNIFICATION

(a) Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee of the District, or an individual (including a medical staff appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 *et.seq.* of the California Government Code.

(b) Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permnnitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with

the law of California, including Sections 825 *et.seq.* of the California Government Code.

(c) Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession.

Section 6. FISCAL YEAR

The fiscal year of the District shall commence on the first day of July and each year shall end on the last day of June of the each year.

Section 6 Annual Audit removed see section see VI Section, 2, b.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE III

BOARD OF DIRECTORS

Section 1. ELECTION

The Board of Directors shall be elected as provided in "The Local Healthcare District Law," which shall also govern eligibility for election to the Board of Directors.

Section 2. POWERS

The Board of Directors shall have and exercise all the powers of a Healthcare District as set forth in the Healthcare District Act. Specifically, the Board of Directors shall be empowered as follows:

a) To control and be responsible for the overall governance of the District, including the provision of management and planning.

b) To make and enforce all rules and regulations necessary for the administration, government, protection and maintenance of hospitals and other facilities under District jurisdiction and to ensure compliance with all applicable laws.

c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the District, the Hospital, and affiliated entities as specified herein and consistent with Board of Directors' Policies. The Board shall also retain legal counsel and independent auditors as needed for District and Hospital operations.

d) To authorize the formation of other affiliated or subordinate organizations which they may deem necessary to carry out the purposes of the District.

e) To periodically review and develop a strategic plan for the District and the Hospital.

f) To determine policies and approve procedures for the overall operation and affairs of this District and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

g) To enter into Joint Powers Agreements with other public entities, and to carry out the District's responsibilities in regard to such Joint Powers Authority as prescribed by law.

h) To evaluate the performance of the Hospital in relation to its vision, mission and valuesgoals.

i) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

j) To be ultimately accountable for the safety of patients and staff, and quality of care, treatment and services.

k) All powers of the Board of Directors, which are not restricted by statute, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed by or with responsibilities to the District, to be exercised in accordance with that delegation.

l) In the event of a vacancy in any Board office established by Article V of these Bylaws (ChairPresident, Vice ChairPresident, etc.), the Board of Directors shall select someone to fill such vacancy and to serve until the next regular election of officers, unless such person earlier resigns or is removed in accordance with said Article.

m) To do any and all other act and things necessary to carry out the provisions of these bylaws or of the provisions of the Local Healthcare District Law.

Section 3. COMPENSATION

The Board of Directors shall serve without compensation except that the Board of Directors, by a majority vote of the members of the Board, may authorize payment not to exceed one hundred dollars ($100) per meeting, or for each committee meeting or other meeting authorized by Board or Chair of the Board, and not to exceed five (5) meetings a month as compensation to each member of the Board of Directors, in accordance with Section 32103 of the California Health and Safety Code, as amended.

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

A budget for the Board of Directors educational expenses is developed each year. At least annually, the entire Board will review their travel and incidental expenses.

Section 4. VACANCIES

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IV

MEETINGS OF DIRECTORS

Section 1. REGULAR MEETINGS

The regular meetings of the Board of Directors of the Northern Inyo Healthcare District shall be held monthly, or as periodically determined by the Board, on such day and at such time as the Board of Directors shall from time-to-time establish by resolution and/or motion.

Section 2. SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by the ~~Chair~~ President or three (3) Directors, and notice of the holding thereof shall be received by each member of the Board of Directors at least twenty-four hours (24) before said meeting.

Section 3. QUORUM

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business, and motions and resolutions shall be passed if affirmatively voted upon by a majority of those voting at the time the vote is taken. If a member has a conflict of interest and may not vote they may not be counted towards a quorum.

Section 4. ADJOURNMENT

A quorum of the Board of Directors may adjourn any Directors' meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum, a majority of the Directors present at any Directors' meeting, either regular or special, may adjourn until the time fixed for the next regular meeting of the Board of Directors. An adjourned meeting can consider only the business of the meeting which was adjourned. An adjourned meeting must be completed prior to the convening of a new meeting.

Section 5. PUBLIC MEETINGS

All meetings of the Board of Directors whether regular, special or adjourned, shall be open to the public in accordance with Government Code Sections 54950 through 54961, commonly known as the Ralph M. Brown Act provided, however, that the foregoing shall not be construed to prevent the Board of Directors from holding executive sessions to consider the appointment,

employment, promotion, demotion or dismissal of an employee or public officer, as the term is defined by law, or to hear complaints or charges brought against such officer or employee, to discuss labor negotiations, or to consult with legal counsel concerning litigation to which the District is a party, and prospective and probably litigation, as provided in Sections 54956.7 through 54957 of the Government Code. In addition, closed sessions may be held to discuss trade secrets as defined in Government Code Section 54956.7, and provided in Section 32106 of the Health and Safety Code. To the extent not in violation with the Ralph M. Brown Act or the California Public Records Act, and California Health and Safety Code Section 32155, any information and reports protected from discovery by California Evidence Code Section 1157 that are provided to the Board of Directors by the Medical Staff shall be presented and discussed in closed sessions, maintained as confidential and not released except as required by applicable laws.

Section 6. MINUTES

A book of minutes of all public meetings of the Board of Directors shall be kept at the principal office of the District and shall be open for public inspection upon request.

Section 7. SCOPE OF MOTIONS AND RESOLUTIONS

The decisions of the Board establishing general rules or procedures of the District and/or procedures affecting the Directors shall be by motion or resolution. All motions or resolutions become effective at the time voted upon affirmatively by a majority of the Directors voting at the time the vote is taken.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE V

OFFICERS AND THEIR DUTIES

Section I. OFFICERS

The officers of the Board of Directors of the Northern Inyo Healthcare District shall be a President, Vice President and a Secretary, a Treasurer, and "Member at Large".

Section 2. ELECTION OF OFFICERS

a) The officers of the Board of Directors shall be chosen every year by the Board of Directors at the December meeting of every calendar year; and each officer shall hold office for one year, or until a successor shall be elected and qualified, or until the officer is otherwise disqualified to serve.

b) Ifan officer of the Board, other than the President, is unable to act, the Board may appoint some other member of the Board of Directors to do so, and such person shall be vested temporarily with all the functions and duties of the office.

c) Any officer on the Board of Directors may resign at any time or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the Board of Directors. In the event of a resignation or removal of an officer, the Board of Directors shall elect a successor to serve for the balance of that officer's unexpired term.

Section 3. DUTIES

a) President: The Board of Directors shall elect one of their members to act as President. If at any time the President shall be unable to act, the Vice President shall assume office and perform the duties of the office. If the Vice President shall also be unable to act, then the Secretary~~/Treasurer~~ shall assume the office and shall immediately conduct a Board election to appoint a President, and such person shall be vested temporarily with all the functions and duties of the President.

The President, or member of the Board of Directors acting as such, as above provided:

(1) Shall preside over all meetings of the Board of Directors, and shall review all requested agenda items submitted to the President and the ~~President &~~ Chief Executive Officer pursuant to the Board's written policies;

(2) Shall sign as President on behalf of the District all instruments in writing that the President has been specifically authorized by the Board to sign;

(3) Shall act as the main liaison between the Board and management for communications and oversight purposes;

(4) Shall appoint or remove members of committees subject to approval by the Board of Directors.

(5) Shall have, subject to the advice and control of the Board of Directors, general responsibility for the affairs of the District and generally shall discharge all other duties which shall be required of the President by the Bylaws of the District.

b) Vice President: The Vice President shall, in the event of death, absence, or other inability of the President, exercise all the powers and perform all the duties herein given to the President.

c) Secretary:

(1) The member of the Board who is elected to the position of Secretary shall act in this capacity for both the District and the Board of Directors;

(2) Shall be responsible for seeing that records of all actions, proceedings and minutes of meetings of the Board of Directors are properly kept and are maintained at the District offices;

(3) Shall serve, or cause to be served, all notices required either by law or these bylaws, and in the event of absence, inability, refusal or neglect to do so, such notices may be served by any person thereunto directed by the President of the Board of Directors of this District;

(4) Shall be responsible for seeing that the seal of this District is in safekeeping at the District and shall use it under the direction of the Board of Directors;

(5) Shall perform such other duties as pertains to the office and as are prescribed by the Board of Directors. The Secretary may delegate his or her duties to appropriate management personnel.

d) Member at Large: The Member at Large shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the Board of Directors.

e) Treasurer:

(1) Shall have the responsibility for the safekeeping and disbursal of funds in the treasury of the District in accordance with the provisions of the "Local Healthcare District Law" and in accordance with resolutions, procedures and directions as the Board of Directors may adopt;

(2) Shall receive monthly reports from management with respect to the financial condition of the District and shall present such reports to the Board of Directors as directed by the Board of Directors;

(3) Shall perform such other duties as they pertain to this office and as prescribed by the Board of Directors. The Treasurer may delegate his or her duties to appropriate management personnel.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VI

COMMITTEES

Section 1. COMMITTEES

a) The Board of Directors may sit as a Committee of the Whole on any and all matters, or may create such Standing Committees, ad hoc Committees, or task force Committees as are deemed appropriate.

b) The duties of these committees shall be to develop and make policy recommendations to the Board and to perform such other functions as shall be stated in these bylaws or in the resolution or motion creating the committee. Each Standing Committee will include two Board members, one of whom shall act as President of the Standing Committee. The President and Board members of each Committee shall be appointed by the President of the Board and approved by the Board at the second meeting of January of each calendar year and shall serve for one year, or until a successor has been appointed and approved. Other members of each standing committee are automatically members with one year terms, or until a successor has been appointed and approved. The two Board members shall be the only voting members of each Standing Committee, unless otherwise provided for in these Bylaws.

c) Special or ad hoc committees may be appointed by the President with the approval of the Board of Directors for such specific tasks as circumstances warrant. Special committees may consist only of Board members, or they may include individuals not on the Board. Voting rights on special committees shall be specified by the Board of Directors at the time the committee is created. No committee so appointed shall have any power or authority to commit the Board of Directors or the District in any manner; however, the Board may direct the particular committee to act for and on its behalf, by special vote.

d) All committees shall keep minutes of each meeting and shall maintain their minutes at the District offices and shall submit reports to the Board as requested.

e) Aside from committees upon which the President is appointed as a voting member, the President of the Board shall be an ex officio member of each committee, without being a voting member. The President shall be notified of all committee meetings.

f) Standing committees of the Board of Directors as set forth below shall continue in existence until discharged by specific action of the Board of Directors:

1. Quality and Safety
2. Finance Committee
3. Governance Committee
4. Community Benefit Committee

Section 2. STANDING COMMITTEES

a) Quality and Safety Committee: The Board shall sit as a Committee of the Whole on all quality and safety issues, being advised by the President and Chief Executive Officer, the Medical Executive Committee, the Chief of Staff, and Medical Staff members from time to time. The Board shall:

Formatted: Underline

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical staff s fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

(3) Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

- completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;
- completed applications for reappointment of medical staff, staff category, clinical privileges;
- establishment of categories of Allied Health Professionals permitted to practice at the hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(4) Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(5) Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(6) Analyze findings and recommendations- from the Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(7) Assess the effectiveness and results of the quality review, utilization review,

performance improvement, and risk management programs.

(8) Perform such other duties concerning safety and quality of care matters as may be necessary.

b) Finance Committee: The Board shall sit as a Committee of the Whole on matters pertaining to the finances of the District and its oversight role pursuant to the JPA Agreement. The Finance Committee in consultation with the Chief Executive Officer and upon the recommendation of the Authority shall be responsible for reviewing, adopting, and monitoring the annual budget and, as appropriate, its long term capital expenditure plan. The Committee shall oversee retention of auditors and approve audits, and business plans pursuant to subsidiary organizations.

Formatted: Underline

c) Governance Committee: ~~Members of this Committee shall include two representatives from the Board of Directors~~At the discretion of the Board two members may be assigned along with ~~and~~ the Chief Executive Officer. The two members of the Board of Directors shall be the only members of the Committee with voting privileges. The function of this Committee is to recommend amendments or changes to the District bylaws and Board policies. This Committee shall commence an on-going review of the Bylaws to ensure that the Bylaws are maintained current and consistent with the Board's and the District's functions and operations. This Committee shall also review the Board Policy Manual, at least every four years, and make recommendations to the Board on any additions or deletions of policies. The Committee shall also be responsible for development of a format for the evaluation of the Chief Executive Officer, and for the conduct of a periodic evaluation. This Committee shall also be responsible for developing a format and administering the Board of Directors' periodic self-evaluations. Such Board evaluation shall include an annual assessment of resolution of safety and quality issues and initiatives.

Formatted: Underline

d) Community Benefit Committee: ~~The members of this Committee shall be two members of the Board of Directors~~The Baord shall sit as a Committee of the Whole on community benefit matters. The Committee shall be assisted, as needed, by the Chief Executive Officer ~~and the Director of Community and Government Affairs,~~ along with any other staff or representatives designated by the Committee. The ~~two members of~~ the Board of Directors shall be the only members of the Committee with voting privileges. This Committee shall have general responsibility for development ~~and implementation~~ of an achievable Community Benefit Initiative, including ~~identification~~ recommendation of a process by which the initiative can be pursued, achieved, and sustained. The Committee will assess and marshal resources available to the District to advance the Initiative in a manner responsive to community health needs, prioritized based on a balance of need and outcome attainability, and, where helpful, in partnership with District and community stakeholders.

Formatted: Underline

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VII

CHIEF EXECUTIVE -OFFICER

Section 1 GENERAL PROVISIONS

The Board of Directors shall have the authority to employ and discharge the Chief Executive Officer and shall specify the terms and conditions of the person's employment. The performance of the Chief Executive Officer will be evaluated on an annual basis by the Board of Directors based on performance criteria established from time to time by the Board of Directors.

The Chief Executive Officer shall be responsible for the overall management of the Hospital and District, and has the necessary and full authority to effect this responsibility subject to the Board's oversight, any policies and directives issued by the Board, and as called upon pursuant to the JPA Agreement. Chief Executive Officer is directly responsible to the Board of Directors and the Authority, for the management of the Hospital and all of its departments and activities.

Section 2. QUALIFICATIONS, DUTIES AND RESPONSIBILITIES

Qualifications, specific duties and responsibilities of the Chief Executive Officer shall be set forth in the appropriate section of the Policy Manual and any employment agreement with the Chief Executive Officer.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VIII

MEDICAL ADMINISTRATION IN THE HOSPITAL

Section 1. ESTABLISHMENT OF A MEDICAL STAFF

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law (H. & Safety Code 32000, *et.seq.),* whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit and care for patients in the Hospital. The Board of Directors shall appoint the Medical Staff, which shall be an integral part of the Hospital. The Medical Staff derives its authority from the Board of Directors and shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the Board.

The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded full access to the Board through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the Board of Directors for the discharge of those duties and responsibilities set forth in the Medical Staff s Bylaws, Rules and Regulations, and Policies, and as delegated by the Board of Directors from time to time.

Section 2. BYLAWS, RULES AND REGULATIONS

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the Board of Directors.

Section 3. BOARD ACTION ON MEMBERSHIP AND CLINICAL PRNILEGES

(a) Medical Staff Responsibilities: The Medical Staff is responsible to the Board of Directors for the quality of care, treatment and services rendered to patients in the Hospital. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as

provided in Section 3(d). The Medical Staff adopt and forward to the Board or committee of the Board specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors.

(b) Criteria for Board Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(c) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(d) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Executive Committee immediately of any such action.

Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual and when no person authorized to take such action by the Medical Staff is available, provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized. A suspension by the Chief Executive Officer that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

(e) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The

hearing and appellate procedures employed by the Board of Directors upon referral of such matters shall be consistent with the Local Healthcare District Law at Section 32150 *et. seq.* of the Health & Safety Code, and those specified in the Medical Staff Bylaws, Rules and Regulations to the extent not inconsistent therewith. Any doctor or other practitioner who feels aggrieved by any adverse recommendation or deprivation of Medical Staff status or clinical privileges shall be required, as a condition to exercising his or her right of appeal to the Board, to pursue his or her appeal through orderly channels of appeal and at the proper time and in the manner prescribed by the Bylaws and procedures of the Medical Staff of this hospital. When the Medical Staff has made its final ruling and decision concerning the appeal of any aggrieved doctor or practitioner in accordance with the Bylaws of the Medical Staff, and such doctor or practitioner then desires to appeal to the Board, he or she shall give notice in writing to the Hospital Administrator within ten (10) days next following the date of the entry of the final order of the Medical Staff. Said notices must state in substance the grievance made and complained of, and must be given in the time and manner herein specified, or the Board shall not take cognizance thereof except at its discretion. Ifsaid notice is so given within said time, then it shall be the duty of the Board to then consider such grievance in its entirety and render the decision of the Board in writing, and deliver a copy of its decision and findings to the aggrieved doctor or practitioner. Such decision shall be final.

The Medical Staff shall have the right to be heard, through its Chief of Staff or designee at meetings of the Board.

Section 4. ACCOUNTABILITY TO THE BOARD

The Medical Staff shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

Section 5. DOCUMENTATION

The Board shall receive and act upon the findings and recommendations emanating from the activities required by Section 4. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Board can take appropriate action.

Section 6. COMPENSATED MEDICAL DIRECTOR POSITIONS

Compensated Medical Director positions shall be responsible to the Chief Executive Officer and the Medical Staff for documentation of activities related to their assignment. Compensated Medical Directors shall be approved by the Chief Executive Officer and for fit and compensation amount. Medical Staff may appoint Service Directors, the slate of Service Directors must be approved by the Board of Directors.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IX

AMENDMENT

These Bylaws may be amended by affirmative vote of a majority of the total number of members of the Board of Directors at any regular or special meeting of the Board of Directors, provided a full statement of such proposed amendment shall have been sent to each Board member not less than forty-eight (48) hours prior to the meeting.

Affirmative action may be taken to amend these Bylaws by unanimous vote of the entire Board membership at any regular or special meeting of the Board of Directors, in which event the provision for forty-eight (48) hours notice shall not apply.

Presi ent, Board of Direct ors

S ,201s

AGREEMENT FOR EMPLOYMENT
OF
CHIEF EXECUTIVE OFFICER

This EMPLOYMENT AGREEMENT ("AGREEMENT") is made as of this _____ day of _____, 2018, by and between KEVIN S. FLANIGAN, MD ("FLANIGAN") and NORTHERN INYO HEALTHCARE DISTRICT ("DISTRICT").

RECITALS

A. DISTRICT is a Local Healthcare District duly organized and existing under the laws of the State of California and more specifically pursuant to the provision of Health and Safety Code *§§ 32000*, et seq. known as the Local Healthcare District Law.

B. DISTRICT owns and operates NORTHERN INYO HOSPITAL ("HOSPITAL"), an acute care licensed hospital facility located in Bishop, California.

C. The DISTRICT engaged FLANIGAN as its Chief Executive Officer since September 14, 2015, which arrangement expired as of February 16, 2018 and was thereafter extended until _____, 2018.

D. The parties now wish to renew the employment agreement pursuant to the terms and provisions of this Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL COVENANTS AND CONDITIONS CONTAINED HEREIN, THE PARTIES AGREE AS FOLLOWS:

AGREEMENT

1. Title and Scope of Employment As of the Effective Date, FLANIGAN shall continue as the Chief Executive Officer ("CEO") of HOSPITAL. In this regard, FLANIGAN agrees to devote such amount of time to the conduct of the business of HOSPITAL as may be reasonably required to effectively discharge his duties, subject to the supervision and direction of District's Board of Directors. FLANIGAN agrees to perform those duties and have such authority and powers as are customarily associated with the office of Chief Executive Officer of a licensed general acute care hospital and as more fully set forth in **Exhibit 1**, attached hereto and made a part hereof. In addition to the foregoing, the specific duties and obligations of FLANIGAN shall include, without limitation, as prescribed by the California Health Care District Law (*Health & Safety Code § 32000, et seq.*, and other applicable State and Federal law). The DISTRICT reserves the right to modify this position and duties at any time in its sole and reasonable discretion. FLANIGAN acknowledges and understands that as the CEO of a Healthcare District, he is a public officer and a public employee pursuant to California Law.

2. Term of Employment/At-Will Employment The term of employment shall be for a term of four (4) years beginning _____, 2018, (the "EFFECTIVE DATE") and terminating on _____, 2022. At all times, FLANIGAN shall

be an "at will" employee as provided in Section 32121(h) of the *California Health & Safety Code ("the CODE")* and shall serve at the pleasure of the Board of Directors of the DISTRICT. FLANIGAN acknowledges that "at will" employees may be terminated by the DISTRICT at any time, with or without cause and without notice or an opportunity to be heard regarding such employment decisions and all such employees may voluntarily terminate their employment at any time.

3. Place of Employment Performance of services under this Agreement shall be rendered in the City of Bishop and the County of Inyo and within the boundaries of the DISTRICT (including satellite offices and facilities), subject to necessary travel requirements for the position and duties described herein.

4. Loyal and Conscientious Performance of Duties FLANIGAN represents and warrants to the best of his ability and experience, that he will at all times loyally and conscientiously perform all duties and obligations to the DISTRICT during the term of this Agreement. As an exempt salaried senior management employee, he shall work such hours as is required by the nature of his job description and duties.

5. Devotion of Full Time to the DISTRICT Business

5.1 FLANIGAN shall diligently and conscientiously devote his entire productive time, ability, energy, knowledge, skill, attention and diligent efforts to the furtherance of his duties and obligations to the DISTRICT during the term of this Agreement.

5.2. During the term of this Agreement, FLANIGAN shall not engage in any other business duties or pursuits, nor render any services of a commercial or a professional nature, to any other person, organization or entity, whether for compensation or otherwise, without written consent of the DISTRICT, which consent shall be within the sole and absolute discretion of the DISTRICT.

5.3 This Agreement shall not be interpreted to prohibit FLANIGAN from making personal investments or conducting private business affairs, so long as those activities do not materially or substantially interfere or compete in any way with the services required under this Agreement. FLANIGAN shall not directly or indirectly, acquire, hold, or obtain any ownership of other financial interest in any business enterprise competing with a or similar in nature to the business of the DISTRICT or which may be in contravention of any conflict-of-interest code or regulations adopted by any federal, state or local agency, prohibition, law, rule, regulation, or ordinance, including any conflict-of-interest code adopted by the DISTRICT.

6. Compensation and Benefits

6.1. Base Salary. FLANIGAN shall be paid at the rate of an annual salary of ***Three Hundred and Twenty Five Thousand Dollars ($325,000)*** per year ("Base Salary") . Said sum shall be paid in equal installments on the same schedule as pay periods for DISTRICT employees.

6.2 Retirement or Pension Benefits. FLANIGAN shall be eligible to participate in all employee benefit programs of the DISTRICT offered from time to time during the term of this Agreement by the DISTRICT to employees or management employees, to the extent FLANIGAN qualifies under the eligibility provisions of the applicable plan or plans, in each case consistent with the DISTRICT's then-current practice as approved by the Board of Directors from time to time. Subject to the extent financially feasible for the DISTRICT, the foregoing shall not be construed to require the DISTRICT to establish such plans or to prevent the modification or termination of such plans once established, and no such action or failure thereof shall affect this Agreement. FLANIGAN recognizes that the DISTRICT has the right, in its sole discretion, to amend, modify, or terminate its benefit plans without creating any rights in his.

6.3 Paid Time Off. FLANIGAN shall be entitled to Paid Time Off ("PTO") accrued at the maximum pay period accrual amount of 12.307 hours for a total of 320 hours accrued per year. The maximum amount of allowed PTO to be available is 640 hours. Any accrual resulting in an amount greater than 640 hours shall be paid out in accordance with District policy.

6.4 Health Insurance and other Miscellaneous Benefits. FLANIGAN shall receive health insurance, dental coverage, and other miscellaneous fringe benefits of employment that are similar to those offered to managerial and other full-time supervisory employees of the DISTRICT. Miscellaneous fringe benefits shall include, but not be limited to $50,000 in life insurance, plus the opportunity to purchase, at his own expense and subject to applicable Internal Revenue Service regulations, additional life insurance beyond that already provided by the DISTRICT to all employees in multiples of one, two or three times his annual base salary.

6.5 Continuing Education and Professional Activities. The DISTRICT encourages FLANIGAN to participate in community functions, continuing education programs, seminars, and other gatherings of professional organizations as needed. In connection herewith, the parties shall meet and confer on a periodic basis to enable FLANIGAN to participate in a reasonable number of these activities, with reasonable tuition, attendance fees, travel and lodging costs being paid by the DISTRICT. Benefits provided under this Paragraph shall include annual dues for membership in one Bishop service club. Time off taken in accordance with this paragraph shall not be considered PTO and shall not be charged against the PTO balance of FLANIGAN. FLANIGAN shall be allowed, at a minimum, forty (40) hours of time off each year for participation in continuing education activities.

7. Performance Review. Each annual anniversary date of employment, the Board of Directors shall conduct a performance review, including salary and compensation in light of his job performance and the DISTRICT may, in the sole discretion of the Board of Directors, adjust salary and compensation by amounts and inclusion or exclusion of benefits as it deems appropriate. There shall be no reduction in salary. Any reduction in benefits must be similar to those suffered at or near the same time by managerial and other full-time supervisory employees of the DISTRICT. Nothing in this paragraph shall be construed to imply or infer an obligation on the part of DISTRICT to increase the salary of FLANIGAN. The Board of Directors, in its

sole and absolute discretion, may conduct such reviews and performance evaluations on a more frequent basis.

8. Indemnification; Directors & Officers Insurance

8.1 Indemnification. The DISTRICT shall indemnify and defend FLANIGAN against reasonable expenses (including reasonable attorney's fees), judgments (excluding any award of punitive damages), administrative fines (but excluding fines levied after conviction of any crime), and settlement payments incurred by him in connection with such actions, suits or proceedings to the maximum extent permitted by law and by the bylaws and governing documents of the DISTRICT in the event FLANIGAN is made a party, or threatened to be made a party, to any threatened or pending civil, administrative, and/or investigative action, suit or proceeding, by reason of the fact that he is or was an officer, manager, or employee of the DISTRICT, in which capacity he is or was performing services within the course and scope of the employment relationship of this Agreement.

8.2 D&O Insurance. The DISTRICT shall use reasonable commercial efforts to maintain Directors & Officers insurance for the benefits of FLANIGAN with a level of coverage comparable to other hospitals and healthcare districts similarly situated with regard to geography, location, and scope of operations.

9. Severance Compensation

9.1 Termination by DISTRICT Without Cause; Pay in Lieu of Notice. In the event FLANIGAN'S employment is terminated by the DISTRICT for any reason other than: (1) "For Cause" (as defined in Section 9.4 below); or (2) due to the death of FLANIGAN, FLANIGAN will be paid, subject to FLANIGAN signing a full release in a form set forth in **Exhibit 3**, a severance pay equal to FLANIGAN's Base Salary for the period commencing on the date that Employee's employment is terminated and extending for a period equal to one (1) year, subject to the limitations of this section (the "Severance Pay"). The Severance Pay will be paid on the same dates specified in Paragraph 6.1 for payment of FLANIGAN's Base Salary. Notwithstanding the foregoing, in no event during the term of this Agreement may monthly Severance Pay compensation paid after termination exceed the number of months remaining of the term of the Agreement at the time of termination. If FLANIGAN goes to work, or contracts to provide services, for another entity engaged in providing health care services during the period in which Severance Pay is being paid by the DISTRICT, regardless of the length of time he is employed, or performs services for such other entity, FLANIGAN shall not be entitled to any further Severance Pay under this Agreement.

9.2 Termination by DISTRICT For Cause. In the event FLANIGAN's employment is terminated by the DISTRICT "For Cause" (as defined in Section 9.4 below), FLANIGAN shall not be entitled to any Severance Pay.

9.3 Termination by FLANIGAN for any Reason; No Severance; Ninety-Day Notice Requested. In the event FLANIGAN terminates his employment with DISTRICT for any reason, FLANIGAN or FLANIGAN's estate will not be entitled to any Severance Pay. Except

in cases of death, FLANIGAN is requested to give the DISTRICT ninety (90) days' prior written notice of his intent to terminate this Agreement for any reason.

9.4 Definitions. For purposes of this Agreement, the following terms have the following meanings:

"For Cause" means termination by DISTRICT of FLANIGAN's employment: (i) by reason of FLANIGAN's serious abuse such as fraud, embezzlement, misappropriation of DISTRICT property, willful dishonesty towards, or deliberate injury or attempted injury to, the DISTRICT; (ii) by reason of FLANIGAN's material breach of this Agreement, including, but not limited to, performing services for a competitor during the term of this Agreement; (iii) by reason of FLANIGAN's intentional misconduct with respect to the performance of FLANIGAN's duties under this Agreement; or (iv) FLANIGAN's repeated failure to perform the essential functions of his job in a satisfactory fashion; provided, however, that no such termination will be deemed to be a termination For Cause unless the DISTRICT has provided FLANIGAN with written notice of what it reasonably believes are the grounds for any termination For Cause and FLANIGAN fails to take appropriate remedial actions during the ten (10) day period following receipt of such written notice.

10. Business Expenses. The DISTRICT shall promptly reimburse FLANIGAN for reasonable and necessary expenditures incurred by him for travel, entertainment, and similar items made in furtherance of his duties under this Agreement and consistent with the policies of the DISTRICT as applied to all management staff. FLANIGAN shall document and substantiate such expenditures as required by the policies of the DISTRICT, including an itemized list of all expenses incurred, the business purposes of which such expenses were incurred, and such receipts reasonably can provide.

11. No Assignment. Due to the unique nature of services being rendered by FLANIGAN to the DISTRICT as provided for herein and that this Agreement is for personal services of FLANIGAN who shall not assign, sublet, delegate, or otherwise convey his rights and obligations pursuant to this Agreement. Any attempt to so assign by FLANIGAN shall be deemed null, void and shall entitle the DISTRICT to immediately terminate this Agreement and FLANIGAN shall not be entitled to compel payment of Severance Pay.

12. Remedies. Enforcement of any provisions of this Agreement shall be by proceedings at law or in equity against any person of entities violating or attempting to violate any promise, covenant, or condition contained herein, either to restrain violation, compel action, or to recover damages. Any and all remedies provided by this Agreement, operation of law, or otherwise, shall be deemed to be cumulative, and the choice or implementation of any particular remedy shall not be deemed to be an election of remedies to the mutual exclusion of any other remedy provided for herein, by operation of law, or otherwise.

13. Attorney's Fee. In the event any action at law or in equity is initiated to enforce or interpret the terms of this Agreement, or arises out of or pertains to this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, costs, and necessary disbursements in addition to any other relief to which that party may be entitled.

14. Integration. It is intended by the parties that this Agreement be the final expression of the intentions and agreements of the Parties. This Agreement supersedes any and all prior or contemporaneous agreements, either oral or in writing, between the parties hereto and contains all the covenants and agreements between the parties. No other agreements, representations, inducements, or promises, not contained in this Agreement shall be valid or binding. Any modification of this Agreement shall be effective only if it is in writing and signed by the party to be charged. In the event of any conflict or inconsistency with any term or provision of this Agreement and any written personnel policy or procedure of the DISTRICT, this Agreement shall prevail, except as may otherwise be prohibited by law.

15. Effect of Waiver No waiver of any breach of any term, covenant, agreement, restriction, or condition of this Agreement shall be construed as a waiver of any succeeding breach of the same or any other covenant, agreement, term, restriction, or condition of this Agreement. The consent or approval of either party to or of any action or matter requiring consent or approval shall not be deemed to waive or render unnecessary any consent to or approval of any subsequent or similar act or matter.

16. Binding Effect. This Agreement shall be binding upon and inure to the benefit of the heirs, executors, administrators, personal representatives, successors, and assigns of each of the parties hereto. This provision shall not supersede or abrogate the provisions of Paragraph 11.

17. Severance. In the event any term or provision of this Agreement is deemed to be in violation of law, null and void, or otherwise of no force or effect, the remaining terms and provisions of this Agreement shall remain in full force and effect.

18. Governing Law, Venue. This Agreement shall be interpreted under the laws of the State of California. Exclusive venue for any legal action under California law shall be Inyo, County, California and, if brought under federal law, the United States District Court for Eastern California in Fresno, California.

19. Attorney Representation. This Agreement has been prepared by Noel M. Caughman, Archer Norris, a Professional Corporation, general counsel of the DISTRICT. FLANIGAN has been advised to seek the advice and counsel of his own legal counsel in reviewing and executing this Agreement. Legal counsel for the DISTRICT has not rendered any advice to FLANIGAN in any matter or form whatsoever.

20. Facsimile Signature. Facsimile signature pages shall be deemed original signature pages and shall be admissible as the same in a court or other tribunal as though such were originals.

21. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

22. **Notice.** Any written notice given pursuant to this Agreement shall be deemed when either (a) personally served or (b) deposited in the United States Mail, first-class postage prepaid, addressed to the respective parties as follows:

To the District: President, Board of Directors
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

To Flanigan: Kevin S. Flanigan, M.D.
2815 Sunset Road
Bishop, California 93514

IN WITNESS WHEREOF, this Agreement is executed as of the day and year first above written.

NORTHERN INYO HEALTHCARE DISTRICT

By _____
JOHN UNGERSMA, M.D., President
Board of Directors

_____
KEVIN S. FLANIGAN, MD

EXHIBIT 1
Job Duties

The job duties of the Chief Executive Officer shall include, but not be limited to, the following:

- To temporarily designate an individual to act for himself in his absence, in order to provide the DISTRICT with administrative direction at all times.
- To carry out all policies established by the Board of Directors and medical staff of HOSPITAL.
- To serve as a liaison officer and channel of communications between the DISTRICT Board of Directors and any of its committees, professional staff and independent contractors, and the medical staff.
- To prepare an annual budget showing the expected receipts and expenditures as required by the Board of Directors and prepare the DISTRICT forecasts.
- To recruit, select, employ, control, manage and discharge all employees.
- To develop and maintain personnel policies and practices for the DISTRICT.
- To insure that all physical plant facilities and properties are kept in good state of repair and in operating condition.
- To supervise all business affairs and insure that all funds are collected and expended to the best possible advantage of the DISTRICT.
- To submit not less than monthly to the Board of Directors or its authorized committees or officers reports showing the professional service and financial activities of the DISTRICT and to prepare and submit such special reports from time to time as may be required or requested by the Board of Directors.
- To attend all meetings of the Board of Directors and, if requested, attend meetings from time to time of board committees, both standing and *ad hoc.*
- To perfect and submit to the Board of Directors for approval and maintain a plan of organization of the personnel and others concerned with the operations of the DISTRICT.
- To prepare or cause to be prepared all plans and specifications for the construction and repair of buildings, improvements, works, and facilities of the DISTRICT.
- To maintain proper financial and patient statistical data and records; data required by governmental, regulatory, and accrediting agencies; and special studies and reports required for the efficient operation of the DISTRICT.
- To represent the Board of Directors as a member, ex-officio, of all its committees and adjunct organizations, including the Medical Staff, the Medical Staff Executive Committee, and Auxiliary organizations, unless the Board of Directors directs otherwise or unless it or FLANIGAN determine that his attendance and participation would be inappropriate or otherwise not in the best interests of the District.

- Attend, or name a designee to attend, in his capacity as an *ex officio member,* all meetings of the Medical Staff and its committees, within the parameters of the Medical Staff Bylaws adopted by the DISTRICT.
- To report to the Board of Directors on a regular basis within the scope of purview of informing the Board concerning the competency and performance of all individuals who provide patient care services at HOSPITAL but who are not subject to the medical staff peer review and privilege delineation process. Such reports shall be received by the Board in executive or closed session pursuant to *Health & Safety Code §32155* and applicable portions of the Ralph M. Brown Act (*Government Code §54900, et seq.*)
- To recruit physicians and other medical providers as same may be needed from time to time to meet medical service needs of the communities served by the DISTRICT.
- To supervise independent contractor professional services agreements between physicians and other medical providers and the DISTRICT.
- To perform any other duties that the Board of Directors may deem to be in the best interests of the DISTRICT.

EXHIBIT 2
PTO Policy

Northern Inyo Hospital Paid Time Off (PTO) bi-weekly accrual amount:

- Included in all Lifetime Benefit Hours (LBH) levels:
  - 64.00 hours – "Holidays" – 8 days times 8.00 hours
  - 56.00 hours – "Sick" – 8.00 hours times 2 days plus 40.00 hours
- First LBH level:
  - 80.00 hours – "Vacation" – 10 days (2 weeks) times 8.00 hours
  - TOTAL annual PTO hours for first LBH level EQUALS 200.00 hours divided by 26 bi-weekly pay periods per year EQUALS 7.69 hours maximum pay period accrual amount
- Second LBH level:
  - 120.00 hours – "Vacation" – 15 days (3 weeks) times 8.00 hours
  - TOTAL annual PTO hours for first LBH level EQUALS 240.00 hours divided by 26 bi-weekly pay periods per year EQUALS 9.23 hours maximum pay period accrual amount
- Third LBH level:
  - 160.00 hours – "Vacation" – 20 days (4 weeks) times 8.00 hours
  - TOTAL annual PTO hours for first LBH level EQUALS 280.00 hours divided by 26 bi-weekly pay periods per year EQUALS 10.77 hours maximum pay period accrual amount

Reference Personnel Policies – Leaves of Absence - PAID TIME OFF (PTO) (08-01):

PTO combines all vacation time, holiday time and sick leave benefits. Full-time and regular part-time employees (benefited employees) earn and accrue a maximum number of hours per pay period to be used for days off with pay including vacations, holidays, and all sick days.

All benefited employees earn PTO according to the following schedule:

Lifetime Benefit Hours (LBH)	Maximum Pay Period Accrual Amount	Number of Pay Periods Per Year	Total PTO Hours Per Year
0.00 to 8,319.99	7.69	26	200.00
8,320.00 to 18,719.99	9.23	26	240.00
18,720.00 or more	10.77	26	280.00

The above hours of PTO are earned only when the benefited employee is paid at least eighty (80) hours during the pay period. Hours above or below 80 will be prorated with a maximum of 1.2. Whenever paid hours consisting of any combination of time worked, PTO or paid absence (excluding "hours" paid by an external source for income replacement) are less than fifty-six (56) hours during the pay period, the employee will earn no PTO for that pay period.

On two designated pay periods in November or December of each year, benefited employees may elect to receive pay for a portion of accrued (earned by not used) PTO to their credit. Employees must leave a minimum of 40 hours in their PTO balance after cash-out.

EXHIBIT 3
Form of Release

SEPARATION AND RELEASE AGREEMENT

This Separation and Release Agreement ("Agreement") is made this _____ day of _____, 20____ by and between Northern Inyo Healthcare District ("Employer") and Kevin S. Flanigan, M.D., an individual ("Employee").

In consideration of the covenants undertaken and the releases contained in this Agreement Employer and Employee agree as follows:

1. Separation of Employment. Employee's last day of employment with Employer is _____, _____.

2. Consideration. For and in consideration of the release of all claims as set forth hereafter, Employer shall pay to Employee the total sum of $_____(the "Severance Payment"). *The Severance Payment shall be subject to all applicable state and federal withholdings.*

The Severance Payment shall be reported by Employer on an IRS form W-2. Employee hereby declares that that the sum paid pursuant to this paragraph 2 represents adequate consideration for the execution of this Agreement and the release of all claims as set forth herein.

The Severance Payment shall be made on the eighth (8^{th}) day after this Agreement is executed by Employee, provided Employee has, before this date, forwarded a copy of the executed Agreement to Employer. If the 8^{th} day falls on a weekend or holiday, the Severance Payment shall be made on the next business day.

The Severance Payment shall be mailed to Employee at the following address:

_____

_____

_____

It is understood and agreed that Employer is not involved with nor liable for the apportionment, if any, of the settlement proceeds between Employee and his attorney(s), if any, and any other person or entity, including, but not limited to, any payment of applicable taxes, other than those payroll taxes withheld in accordance with this paragraph.

3. General Release and Discharge. Employee on behalf of himself, his descendants, dependents, heirs, executors, administrators, assigns, and successors, and each of them, hereby covenants not to sue and fully releases and discharges Employer, its subsidiaries, affiliates and joint ventures, past, present and future, and each of them, as well as its and their trustees, directors, officers, agents, attorneys, insurers, employees, representatives, partners, shareholders, assigns, predecessors and successors, past, present and future, and each of them (hereinafter together and collectively referred to as "Releasees") with respect to and from any and all claims, demands, rights, liens, agreements, contracts, covenants, actions, suits, causes of action, obligations, debts, costs, expenses, attorneys' fees, damages, judgments, orders and liabilities of whatever kind or nature in law, equity or otherwise, whether now known or unknown, suspected or unsuspected, absolute or contingent, and whether or not concealed or hidden, which Employee now owns or holds or which Employee has at any time heretofore owned or held or may in the future hold against said Releasees, arising out of or in any way connected with Employee's employment relationship with Employer, the termination of Employee's employment with Employer, or any other transactions, occurrences, acts or omissions or any loss, damage or injury whatever, known or unknown, suspected or unsuspected, resulting from any act or omission by or on the part of said Releasees, or any of them, committed or omitted prior to the date of this Agreement. With the exception of the amount set forth under Paragraph 2 of this Agreement, such released and discharged claims include, but are not limited to, without limiting the generality of the foregoing, any claim under Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, the Age Discrimination in Employment Act, the Family and Medical Leave Act, the California Fair Employment and Housing Act, the California Family Rights Act, the California Labor Code (excluding a claim under the California Workers' Compensation Act, or a claim for wages due and owing as of the date of this Agreement), ERISA, any claim for retirement benefits pursuant to a retirement plan sponsored by Employer, or any claim for severance pay, bonus, sick leave, holiday pay, life insurance, health or medical insurance or any other fringe benefit. In addition, Employee agrees and covenants not to file any suit, charge or complaint against Releasees with any administrative agency with regard to any claim, demand liability or obligation arising out of his employment with Employer or separation there from. However, nothing in this Agreement shall be construed to prohibit Employee from filing a charge with or participating in any investigation or proceeding conducted by the EEOC or a comparable state or local agency. Notwithstanding the foregoing sentence, Employee agrees to waive his right to recover monetary damages in any charge, complaint or lawsuit filed by Employee or by anyone else on Employee's behalf in any charge or proceeding conducted by the EEOC or a comparable state or local agency.

4. Waiver of Statutory Provision. It is the intention of Employee in executing this instrument that the same shall be effective as a bar to each and every claim, demand and cause of action hereinabove specified. In furtherance of this intention, Employee hereby expressly waives any and all rights and benefits conferred upon him by the provisions of Section 1542 of the California Civil Code and expressly consents that this Agreement shall be given full force and

effect according to each and all of its express terms and provisions, including those related to unknown and unsuspected claims, demands and causes of action, if any, as well as those relating to any other claims, demands and causes of action hereinabove specified. Section 1542 provides:

"A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM MUST HAVE MATERIALLY AFFECTED HIS SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that he may hereafter discover claims or facts in addition to or different from those which he now knows or believes to exist with respect to the subject matter of this Agreement and which, if known or suspected at the time of executing this Agreement, may have materially affected this settlement.

Nevertheless Employee hereby waives any right, claim or cause of action that might arise as a result of such different or additional claims or facts. Employee acknowledges that he understands the significance and consequence of such release and such specific waiver of Section 1542.

5. Waiver of ADEA Claims. Employee expressly acknowledges and agrees that, by entering into this Agreement, he is waiving any and all rights or claims that he may have arising under the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. § 621 et seq., which have arisen on or before the date of execution of the Agreement. Employee further expressly acknowledges and agrees that:

A. In return for the execution of this Agreement, Employee will receive compensation beyond that which he was already entitled to receive before entering into this Agreement;

B. Employee has been advised to consult with legal counsel before signing this Agreement;

C. Employee received a copy of this Agreement on or about_____,_____, and has been informed that he has twenty-one (21) days within which to consider the Agreement; and

D. Employee is informed hereby that he has seven (7) days following the date of execution of this Agreement in which to revoke the Agreement.

Employee may revoke this Agreement in its entirety during the seven (7) days following his execution of this Agreement. Any revocation of the Agreement by Employee must be in writing and hand delivered to Employer during the revocation period. This Agreement will become effective and enforceable against Employee seven (7) days following execution by Employee, unless it is revoked during the seven (7) day period.

6. Confidentiality of Release Agreement. Employee shall keep confidential the terms and conditions of this Agreement, all communications made during the negotiation of this Agreement, and all facts and claims upon which this Agreement is based (collectively referred to as the "*Confidential Settlement Information*"). Neither Employee nor his agents or attorneys shall, directly or indirectly, disclose, publish or otherwise communicate such Confidential Settlement Information to any person or in any way respond to, participate in or contribute to any inquiry, discussion, notice or publicity concerning any aspect of the Confidential Settlement Information. Notwithstanding the foregoing, Employee may disclose the Confidential Settlement Information to the extent he/she is required to do so to his/her legal counsel, accountants and/or financial advisors, or to anyone else as required by applicable law or regulation. Employee agrees to take all steps necessary to ensure that confidentiality is maintained by any and all of the persons to whom authorized disclosure is or was made, and agree to accept responsibility for any breach of confidentiality by any of said persons. Employee shall not make any public, oral or written or otherwise derogatory or negative comments about Employer concerning Employee's employment or the separation thereof; provided, however, that this Agreement does not preclude Employee from giving testimony as may be required by legal process. In the event that Employee is served with legal process which potentially could require the disclosure of the contents of this Agreement, he/she shall provide prompt written notice (including a copy of the legal process served) to Employer.

7. Non-Disparagement. Employee shall not make any public, oral or written or otherwise derogatory or negative comments about Employer or anyone associated with Employer concerning Employee's employment or the separation thereof; provided, however, that this Agreement does not preclude Employee from giving testimony as may be required by legal process. Employee acknowledges and agrees that the obligations set forth in this paragraph 7 are essential and important. Employee agrees his breach of this paragraph will result in irreparable injury to Employer, the exact amount of which will be difficult to ascertain. Accordingly, Employee agrees that if he/she violates the provisions of this paragraph 7, Employer shall be entitled to seek specific performance of Employee's obligations under this paragraph and liquidated damages in the sum of 30% of the Severance Payment**.**

8. Trade Secrets. Employee acknowledges that he has occupied a position of trust and confidence with the Employer prior to the date hereof and has become familiar with the following, any and all of which constitute trade secrets of Employer (collectively, the "*Trade Secrets"*): (i) all information related to customers including, without limitation, customer lists, the identities of existing, past or prospective customers, customer contacts, special customer requirements and all related information; (ii) all marketing plans, materials and techniques including but not limited to strategic planning ; (iii) all methods of business operation and related procedures of the Employer; and (iv) all patterns, devices, compilations of information, copyrightable material, technical information, manufacturing procedures and processes,

formulas, improvements, specifications, research and development, and designs, in each case which relates in any way to the business of Employer. Employee acknowledges and agrees that all Trade Secrets known or obtained by him, as of the date hereof, is the property of Employer. Therefore, Employee agrees that he will not, at any time, disclose to any unauthorized persons or use for his own account or for the benefit of any third party any Trade Secrets, whether Employee has such information in his memory or embodied in writing or other physical form, without Employer's prior written consent (which it may grant or withhold in its discretion), unless and to the extent that the Trade Secrets are or becomes generally known to and available for use by the public other than as a result of Employee's fault or the fault of any other person bound by a duty of confidentiality to the Employer, Employee agrees to deliver to Employer at any time Employer may request, all documents, memoranda, notes, plans, records, reports, and other documentation, models, components, devices, or computer software, whether embodied in a disk or in other form (and all copies of all of the foregoing), relating to the businesses, operations, or affairs of Employer and any other Trade Secrets that Employee may then possess or have under his control. Employee agrees his breach of this paragraph will result in irreparable injury to Employer, the exact amount of which will be difficult to ascertain. Accordingly, Employee agrees that if he violates the provisions of this paragraph 8, Employer shall be entitled to seek specific performance of Employee's obligations under this paragraph.

9. No Admission of Liability. This Agreement is the result of compromise and negotiation and shall never at any time or for any purpose be deemed or construed as an admission of liability or responsibility by any party to this Agreement. The parties continue to deny fully such liability and to disclaim any responsibility whatsoever for any alleged misconduct in connection with this Agreement.

10. Complete Agreement/Modification. This instrument constitutes and contains the entire agreement and understanding concerning Employee's employment, the separation of that employment and the other subject matters addressed herein between the parties, and supersedes and replaces all prior or contemporaneous negotiations, representations, understandings and agreements, proposed or otherwise, whether written or oral, concerning the subject matters hereof. This is an integrated document. This Agreement may be amended and modified only by a writing signed by Employer and Employee.

11. Severability of Invalid Provisions. If any provision of this Agreement or the application thereof is held invalid, such provisions shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to alter substantially this Agreement or obligations of the parties hereto, in which case the Agreement may be immediately terminated.

12. Counterpart Execution; Effect; Photocopies. This Agreement may be executed in counterparts, and each counterpart, when executed, shall have the efficacy of a signed original. Photographic copies of such signed counterparts may be used in lieu of the originals for any purpose.

13. No Assignment. Employee hereby represents that he has not heretofore assigned or transferred, or caused or purported to assign or transfer, to any person any of the claims released herein. If any such transfer or assignment or purported transfer or assignment occurred prior to the execution of this Agreement, Employee hereby agrees to indemnify and hold Employer harmless from and against any and all claims, demands, obligations, debts, liabilities, costs, expenses, rights of action, causes of action or judgments based upon or arising from any such transfer or assignment or purported transfer or assignment. Any assignment after the execution of this Agreement may only be made with the express written approval of all parties hereto. Employer and Employee represent and warrant that, prior to executing this Agreement, each has not filed any complaints or charges of lawsuits with any court or governmental agency against the other based in whole or in part upon any matter covered, related to or referred to in this Agreement.

14. No Third Party Beneficiaries. Nothing contained in this Agreement is intended nor shall be construed to create rights running to the benefit of third parties.

15. Prior Litigation. Employee represents and warrants that, prior to executing this Agreement, he has not filed any complaints or charges of lawsuits with any court or governmental agency against the Employer based in whole or in part upon any matter covered, related to or referred to in this Agreement.

16. Governing Law. This Agreement shall be interpreted under the laws of the State of California. Exclusive venue for any legal action under California law shall be Inyo, County, California and, if brought under federal law, the United States District Court for Eastern California in Fresno, California.

17. Complete Defense. This Agreement may be pled as a full and complete defense, and may be used as the basis for an injunction against any action, claim, suit, worker's compensation action or any other proceeding which may subsequently be instituted, prosecuted or attempted, which is based in whole or in part upon any matter covered, related to or referred to in this Agreement.

18. Attorneys' Fees. In the event of litigation between Employee and Employer relating to or arising from this Agreement, the prevailing party or the party designated as such by the arbitrator or judge shall be entitled to receive reasonable attorneys' fees, costs, and other expenses, in addition to whatever other relief may be awarded, including such fees and costs any may be incurred in enforcing a judgment or order entered in any arbitration or action. Any judgment or order entered in such arbitration or action shall contain a specific provision

providing for the recovery of such attorneys' fees and costs. In addition, any award of damages as a result of the breach of this Agreement or any of its provisions shall include an award of prejudgment interest from the date of the breach at the maximum rate of interest allowed by law.

19. Advice from Counsel. Employee represents and agrees that he has been advised and fully understands that he has the right to discuss all aspects of the Agreement with legal counsel; that he has carefully read and fully understand and appreciates all provisions of this Agreement, and the effect thereof; and that he is voluntarily entering into this Agreement.

20. Future Employment**.** Employee agrees that he is not now or hereafter entitled to employment or reemployment with Employer and he agrees not to knowingly seek such employment on any basis, including as an independent contractor or through an employment agency.

21. Cooperation in Litigation. Employee agrees to cooperate with Employer and its legal counsel with respect to any litigation now pending, or filed in the future in which Employee may be called as a witness to testify either at trial or deposition and to reasonably cooperate with Employer in the preparation of his testimony for same.

22. Notice. All notices and other communications required by this Agreement shall be in writing, and shall be deemed effective: (a) when personally delivered; (b) when mailed by certified or registered mail, return receipt requested; or (c) when deposited with a comparably reliable postage delivery service (such as Federal Express); addressed to the other party at the following address:

EMPLOYER:

_____

_____

Attention: _____

EMPLOYEE:

_____

_____

_____

The parties may change their respective addresses by giving each other prior written notice of the change.

Executed this _____ day of _____,_____, at _____, California.

By _____

Executed this _____ day of _____, _____, at _____, California.

By_____

WAIVER OF 21 DAY CONSIDERATION PERIOD

I, Kevin Flanigan, M.D. hereby acknowledge that I was given 21 days to consider the foregoing Agreement and voluntarily chose to sign the Agreement before the expiration of 21-day period.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED this _____day of _____, _____ at _____, California.

_____
Kevin Flanigan, M.D.

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending January 31, 2018

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	1,130,431	804,423	326,008	6,687,984	5,579,057	1,108,927
Ancillary	2,712,341	2,790,390	(78,049)	19,553,690	19,352,712	200,978
Total Inpatient Service Revenue	3,842,771	3,594,813	247,958	26,241,674	24,931,769	1,309,905
Outpatient Service	9,419,925	8,119,362	1,300,563	59,873,781	56,311,686	3,562,095
Gross Patient Service Revenue	**13,262,697**	**11,714,175**	**1,548,522**	**86,115,455**	**81,243,455**	**4,872,000**
Less Deductions from Revenue						
Patient Service Revenue Deductions	216,873	234,723	(17,850)	1,566,814	1,627,921	(61,107)
Contractual Adjustments	5,589,276	4,493,004	1,096,272	35,366,537	31,161,156	4,205,381
Prior Period Adjustments	(5,050)	(13,400)	8,350	(930,456)	(92,934)	(837,522)
Total Deductions from Patient Service Revenue	**5,801,098**	**4,714,327**	**1,086,771**	**36,002,895**	**32,696,143**	**3,306,752**
Net Patient Service Revenue	**7,461,599**	**6,999,848**	**461,751**	**50,112,560**	**48,547,312**	**1,565,248**
Other revenue	45,519	76,819	(31,300)	339,727	532,779	(193,052)
Total Other Revenue	**45,519**	**76,819**	**(31,300)**	**339,727**	**532,779**	**(193,052)**
Expenses:						
Salaries and Wages	2,044,122	2,328,739	(284,617)	14,832,931	16,150,931	(1,318,000)
Employee Benefits	1,669,527	1,589,908	79,619	11,233,352	11,026,778	206,574
Professional Fees	1,246,598	724,509	522,089	7,394,325	5,024,829	2,369,496
Supplies	707,173	648,488	58,685	5,023,331	4,497,574	525,757
Purchased Services	299,139	360,086	(60,947)	2,067,095	2,497,370	(430,275)
Depreciation	408,925	443,023	(34,098)	2,860,155	3,072,577	(212,422)
Bad Debts	206,571	242,784	(36,213)	1,716,733	1,683,824	32,909
Other Expense	421,906	352,700	69,206	2,850,550	2,446,154	404,396
Total Expenses	**7,003,961**	**6,690,237**	**313,724**	**47,978,473**	**46,400,037**	**1,578,436**
Operating Income (Loss)	**503,157**	**386,430**	**116,727**	**2,473,814**	**2,680,054**	**(206,240)**
Other Income:						
District Tax Receipts	43,955	49,096	(5,141)	307,685	340,506	(32,821)
Tax Revenue for Debt	128,647	165,487	(36,840)	900,527	1,147,731	(247,204)
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	297,000	42,466	254,534	1,521,328	294,522	1,226,806
Interest Income	34,593	16,845	17,748	213,790	116,829	96,961
Interest Expense	(244,887)	(260,547)	15,660	(1,752,703)	(1,807,019)	54,316
Other Non-Operating Income	5,275	2,422	2,853	32,310	16,798	15,512
Net Medical Office	(469,581)	(396,696)	(72,885)	(2,499,621)	(2,751,282)	251,661
340B Net Activity	-	16,987	(16,987)	(3,251)	117,813	(121,064)
Non-Operating Income/Loss	**(204,998)**	**(363,940)**	**158,942**	**(1,279,934)**	**(2,524,102)**	**1,244,168**
Net Income/Loss	**298,159**	**22,490**	**275,669**	**1,193,879**	**155,952**	**1,037,927**

Northern Inyo Healthcare District

Preliminary Financial Indicators as of January 31, 2018

	Target	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17
Current Ratio	>1.5-2.0	2.50	2.41	2.18	2.26	2.45	2.42	2.49	3.39	3.83	3.51	3.41	3.45	3.53
Quick Ratio	>1.33-1.5	2.09	1.99	1.83	1.84	1.82	1.81	2.05	2.84	3.23	2.96	2.88	2.90	2.93
Days Cash on Hand prior method	>75	166.36	165.72	169.35	165.31	140.47	142.06	160.31	154.70	160.60	159.55	160.80	157.10	151.40
Days Cash on Hand Short Term	>75	81.30	83.05	87.18	81.28	53.95	59.26	79.93	79.37	75.71	76.12	77.66	79.99	71.85
Debt Service Coverage	>1.5-2.0	2.73	2.67	2.74	2.78	2.79	2.87	2.34	1.81	1.96	1.91	2.07	2.23	2.17
Operating Margin		4.87	5.79	5.87	7.64	7.49	8.45	6.67	4.71	6.18	6.06	6.01	6.83	6.30
Outpatient Revenue % of Total		69.53	69.25	69.52	69.46	69.13	69.83	66.58	69.86	69.96	69.76	69.43	69.11	69.10
Cash flow (CF) margin (EBIDA to revenue)		4.31	4.05	4.30	4.69	4.82	5.62	3.68	2.48	2.84	2.59	3.41	4.27	3.94
Days in Patient Accounts Receivable	<60 Days	85.90	82.80	81.80	81.40	82.10	81.40	74.10	78.90	89.00	86.00	85.10	76.70	80.80

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

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

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

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

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

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

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

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

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Jan-18 *Fiscal Year Ending June 30, 2018*

Year to date for the month ending January 31, 2018

	154	or	7%	more IP days than in the prior fiscal year
$	1,309,905	or	5.25%	over budget in Total IP Revenue and
$	3,562,095	or	6.3%	over budget in OP Revenue resulting in
$	4,872,000	or	6.0%	over budget in gross patient revenue &
$	1,565,248	or	3.2%	over budget in net patient revenue

Year-to-date Net Revenue was			$	50,112,560
Total Operating Expenses were:			$	47,978,473
				for the fiscal Year To Date
$	1,578,436	or	3.4%	over budget. Salaries and Wages were
$	(1,318,000)	or	-8.2%	under budget and Employee Benefits
$	206,574	or	1.9%	over budget
			76%	Employee Benefits as Percentage of Wages

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

$	2,369,496	or	47.2%	Professional Fees are over budget due to contract labor budgeted as employees
$	404,396	or	16.5%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending

Other Information:

$	2,473,814			Operating Income, less
$	(1,279,934)			loss in non-operating activities resulted in a Net Income
$	1,193,879	or	$ 1,037,927	over budget.
			41.81%	Actual Contractual Percentages for Year versus
			40.24%	Budgeted Contractual Percentages including
$	930,456	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		

Non-Operating activities included:

$	(2,499,621)	loss	$ 251,661	favorable to budget in Medical Office Activities
$	1,521,328		$ 1,226,806	favorable to budget in Grants and Other Contributions

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending January 31, 2018

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	9,067,440	9,366,854	(299,414)
Short-Term Investments	9,074,767	9,126,389	(51,622)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	63,189,156	61,690,891	1,498,266
Less: Allowances	(47,016,868)	(46,157,627)	(859,242)
Other Receivables	1,231,898	1,647,710	(415,811)
Inventories	3,993,471	3,986,524	6,947
Prepaid Expenses	1,714,912	1,782,862	(67,951)
Total Current Assets	**42,348,805**	**42,537,632**	**(188,828)**
Internally Designated for Capital Acquisitions	1,125,321	1,125,271	50
Special Purpose Assets	1,269,436	430,923	838,513
Limited Use Asset; Defined Contribution Pension	1,066,002	984,444	81,558
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	9,317	8,585	733
Revenue Bonds Held by a Trustee	2,366,034	2,205,232	160,802
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,201,496**	**18,119,839**	**1,081,656**
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated Depreciation	77,636,929	77,977,520	(340,591)
Unamortized Bond Costs	-	-	-
Total Assets	**140,937,230**	**140,384,992**	**552,238**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending January 31, 2018

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,120,589	2,125,815	(5,227)
Accounts Payable	1,751,688	2,517,743	(766,055)
Accrued Salaries, Wages & Benefits	5,351,652	5,072,512	279,139
Accrued Interest and Sales Tax	312,947	179,911	133,036
Deferred Income	1,874,288	2,203,660	(329,372)
Due to 3rd Party Payors	1,029,914	1,029,914	-
Due to Specific Purpose Funds	-	44	(44)
Other Deferred Credits; Pension	4,516,133	4,515,401	733
Total Current Liabilities	**16,957,211**	**17,645,000**	**(687,789)**
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	570,727	577,974	(7,247)
Accreted Interest	11,640,935	11,530,387	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**84,539,141**	**84,435,839**	**103,302**
Net Assets			
Unrestricted Net Assets less Income	38,171,441	37,873,229	298,212
Temporarily Restricted	1,269,436	430,923	838,513
Net Income (Income Clearing)	(1,194,122)	(761,670)	(432,452)
Total Net Assets	**39,440,878**	**38,304,152**	**1,136,725**
Total Liabilities and Net Assets	**140,937,230**	**140,384,993**	**552,238**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending January 31, 2018

	Month to Date	FYE 2018 Year-to-Date	FYE 2017 Year-to-Date	Variance from PY	Variance %
Licensed Beds	25	25	25		
Total Patient Days with NB	370	2,214	2,060	154	7%
Total Patient Days without NB	348	2,007	1,864	143	8%
Swing Bed Days	51	229	294	(65)	-22%
Discharges without NB	104	645	621	24	4%
Swing Discharges	10	35	42	(7)	-17%
Days in Month	31	31	31		
Occupancy without NB	11.23	64.74	60.13	4.6	8%
Average Stay (days) without NB	3.35	3.11	3.00	0.1	4%
Average LOS without NB/Swing	3.16	2.91	2.71	0.2	7%
Hours of Observation	741	6,534	5,259	1,275	24%
Observation Adj Days	31	272	219	53	24%
ER Visits All Visits	815	5,752	5,772	(20)	0%
RHC Visits	2,506	18,516	14,632	3,884	27%
Outpatient Visits	4,125	27,713	24,850	2,863	12%
IP Surgeries	14	146	166	(20)	-12%
OP Surgery	105	761	672	89	13%
Worked FTE's	360.18	338.46	323.32	15	5%
Paid FTE's	421.22	386.95	366.08	21	6%
Hours Worked to Hours Paid%	85.5%	87.5%	88.3%	-0.9%	-1%
Payor %					
Medicare		43%	41%	2%	
Medi-Cal		19%	23%	-3%	
Insurance, HMO & PPO		35%	33%	2%	
Indigent (Charity Care)		0.8%	1.2%	-0.3%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending January 31, 2018

	Current Month	Prior Month	Change
Board Designated Funds:	January		
Tobacco Fund Savings Account	$ 1,098,595	$ 1,098,545	50
Equipment Fund Savings Account	$ 26,726	$ 26,726	-
Total Board Designated Funds:	**$ 1,125,321**	**$ 1,125,271**	**$ 50**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,158,859	$ 320,346	$ 838,513
Nursing Scholarship Savings Account	$ 10,448	$ 10,448	$ -
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,053	$ 100,053	$ -
Total Specific Purpose Funds:	**$ 1,269,436**	**$ 430,923**	**$ 838,513**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,394,758**	**$ 1,556,194**	**$ 838,564**

NORTHERN INYO HEALTHCARE DISTRICT

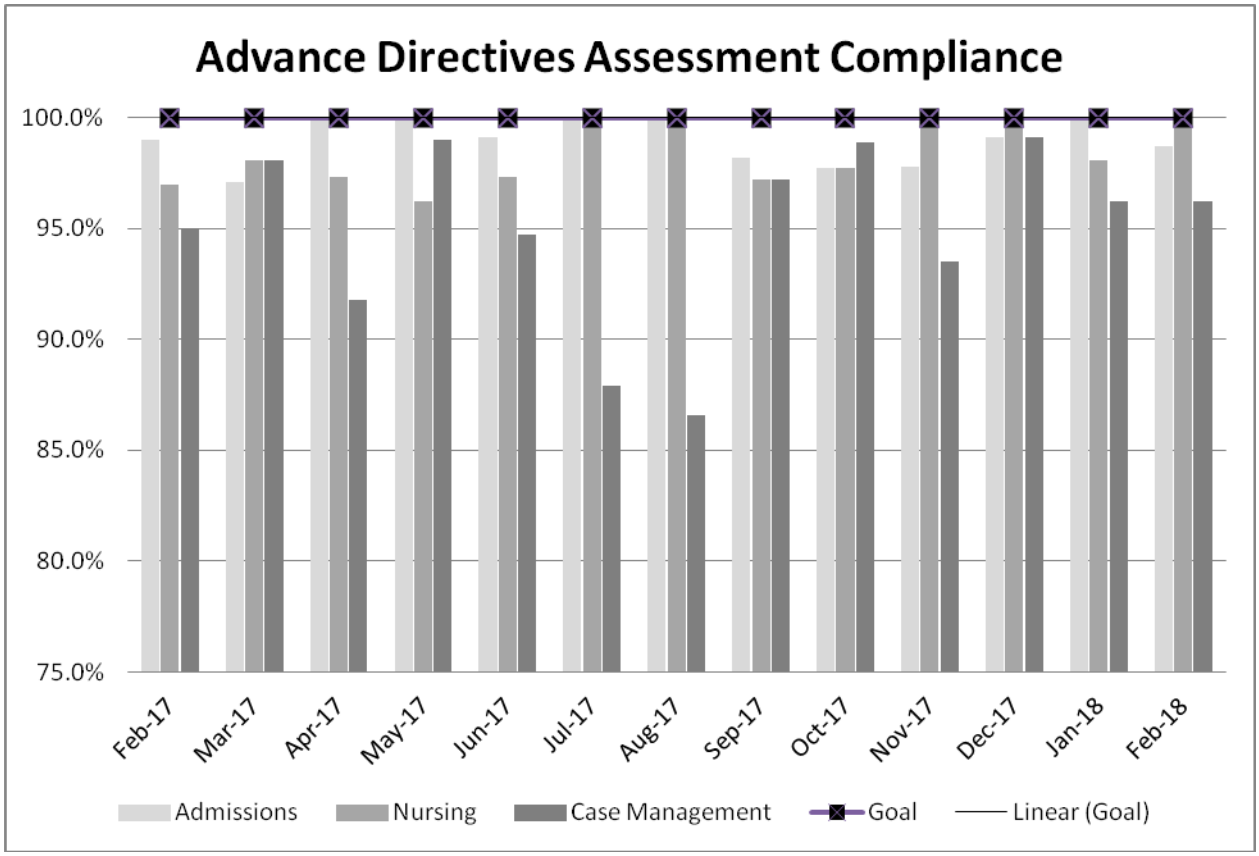
Investments as of January 31, 2018

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	31-Jan-18	01-Jan-18	Local Agency Investment Fund	Northern Inyo Hospital	1.35%		8,824,766.53
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				Short Term Investments			9,074,766.53
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		$	10,824,766.53
1	31-Jan-18	01-Jan-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.35%	$	1,066,001.80
				LAIF PENSION INVESTMENTS		$	1,066,001.80

2013 CMS Validation Survey Monitoring-March 2018

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.

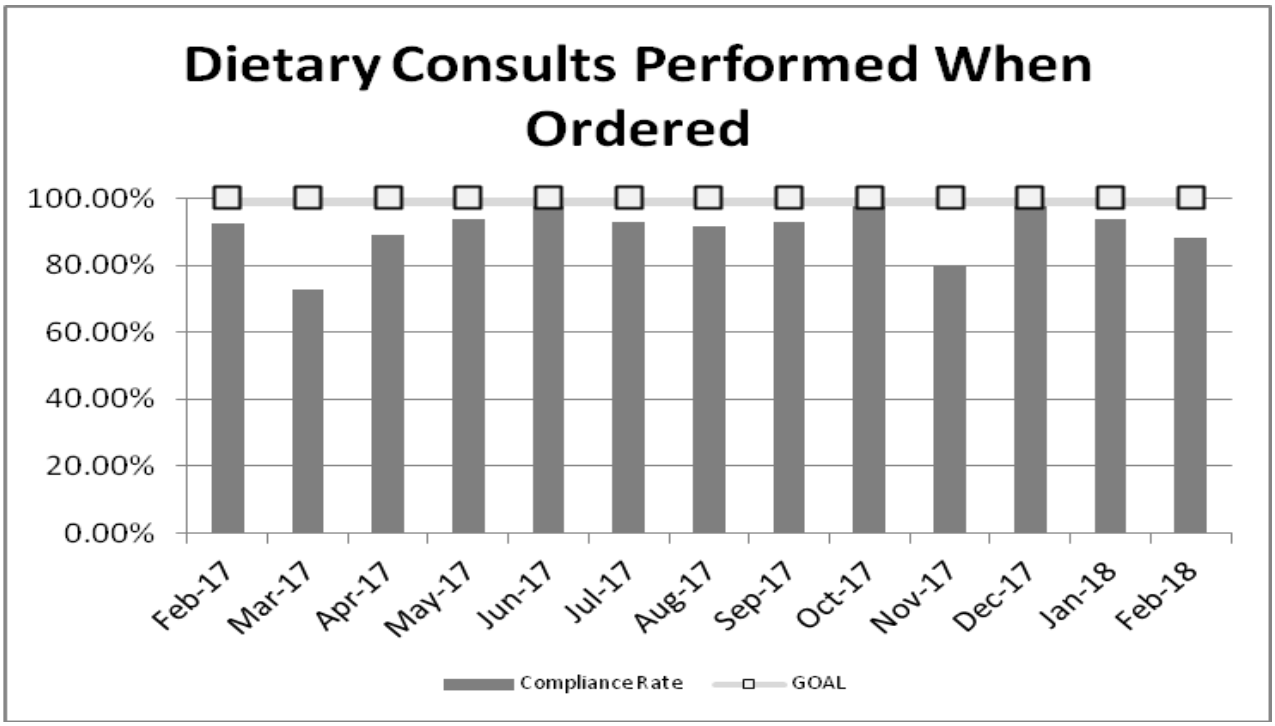


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

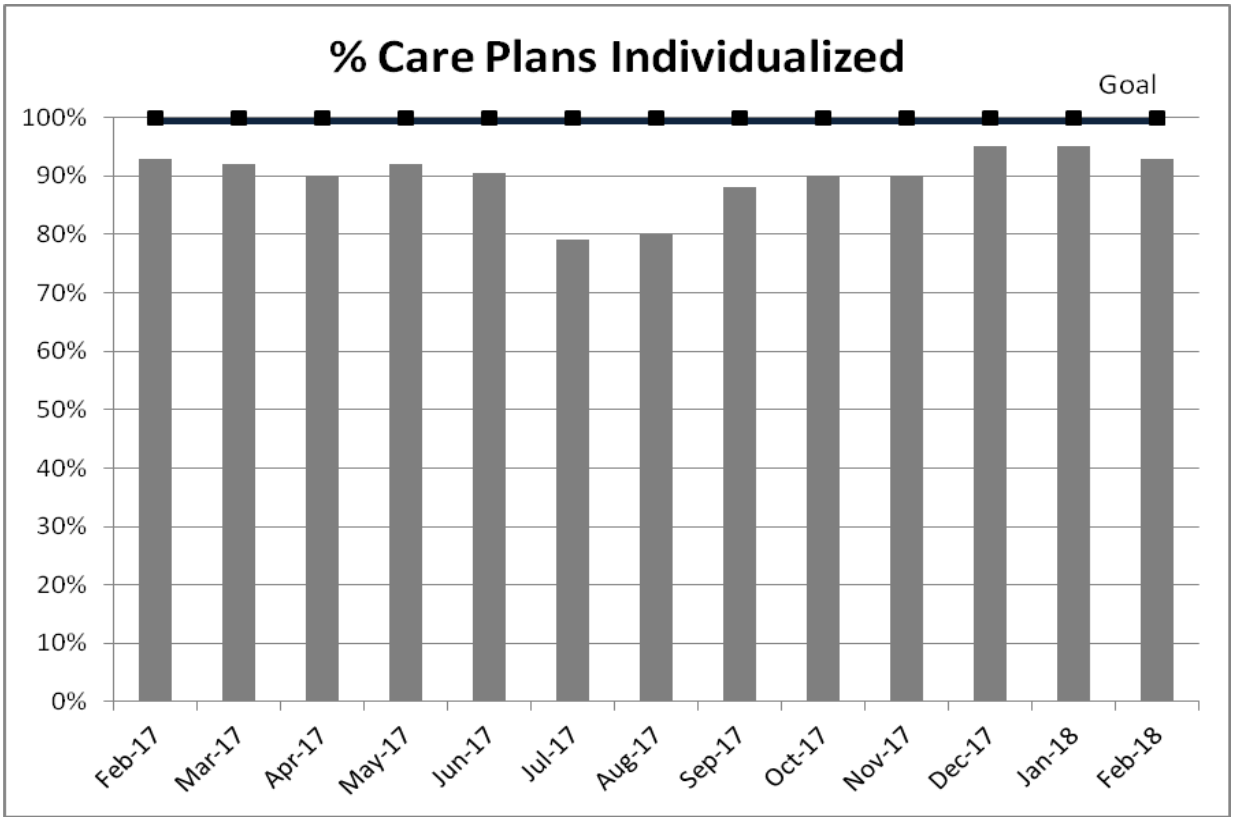
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    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.

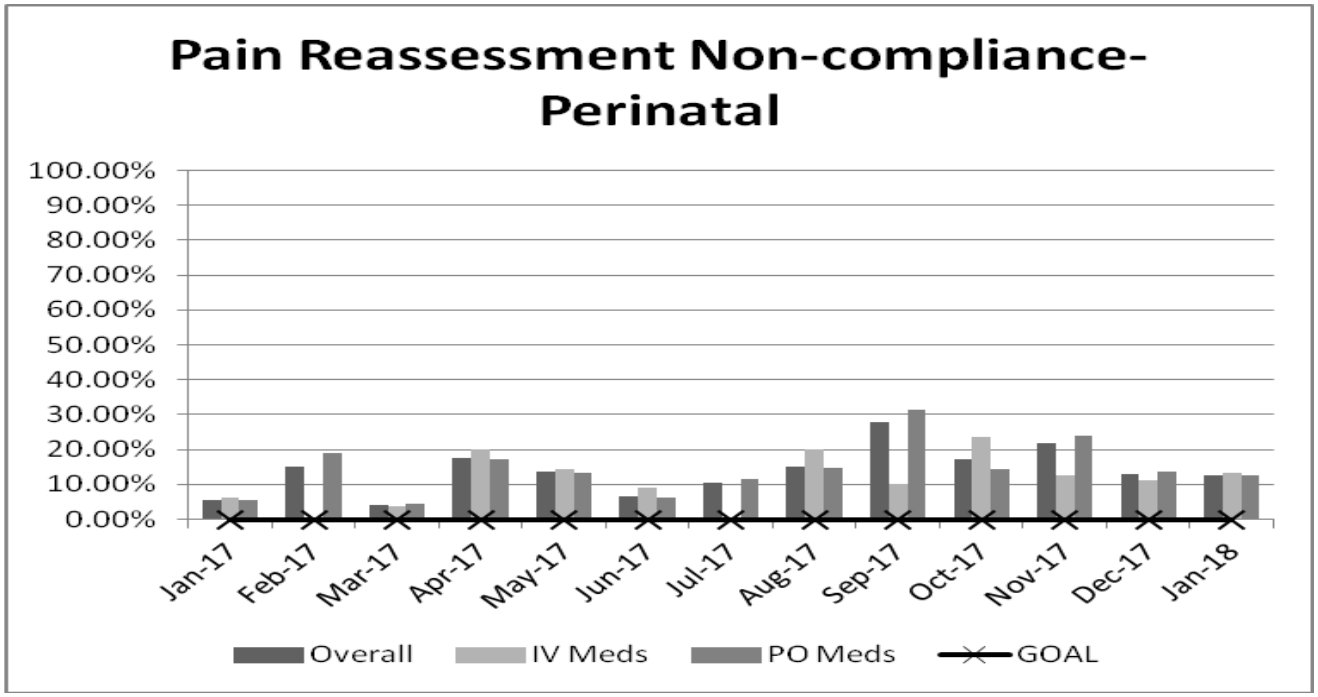


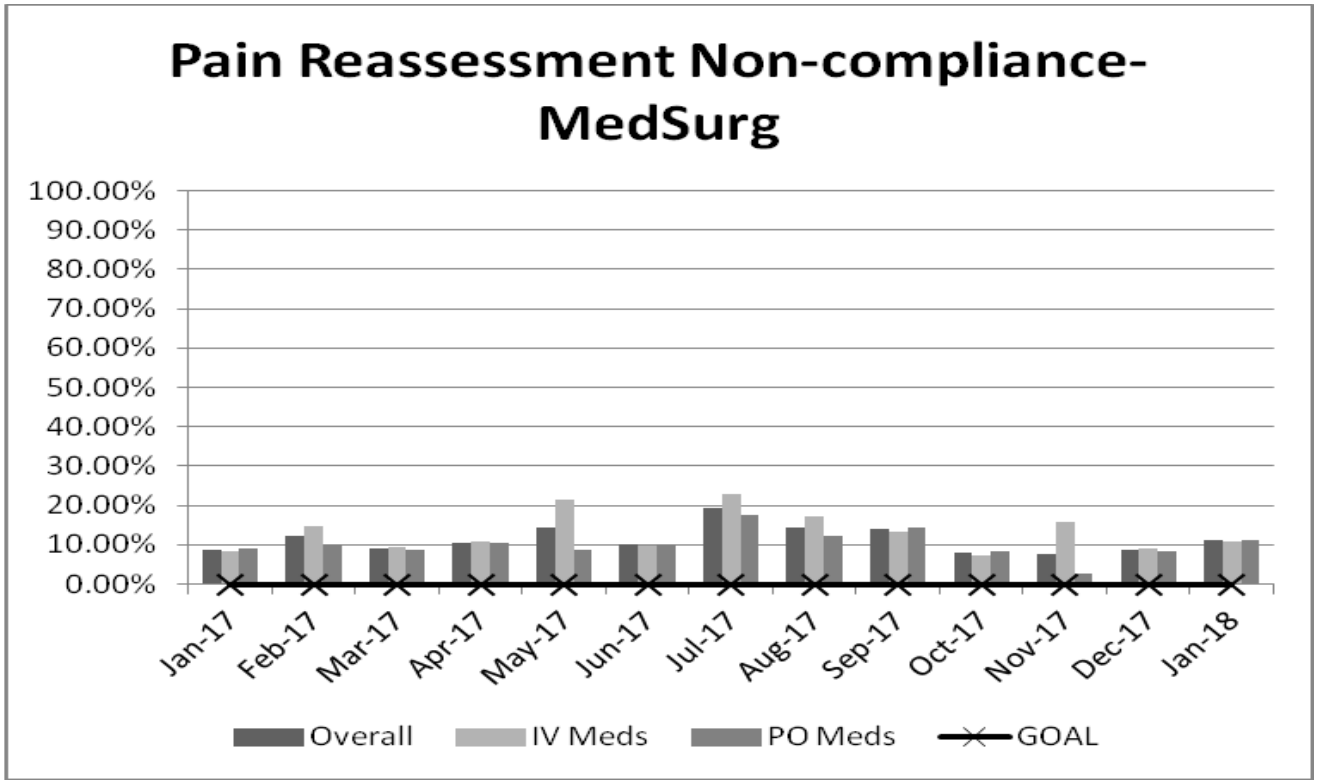
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

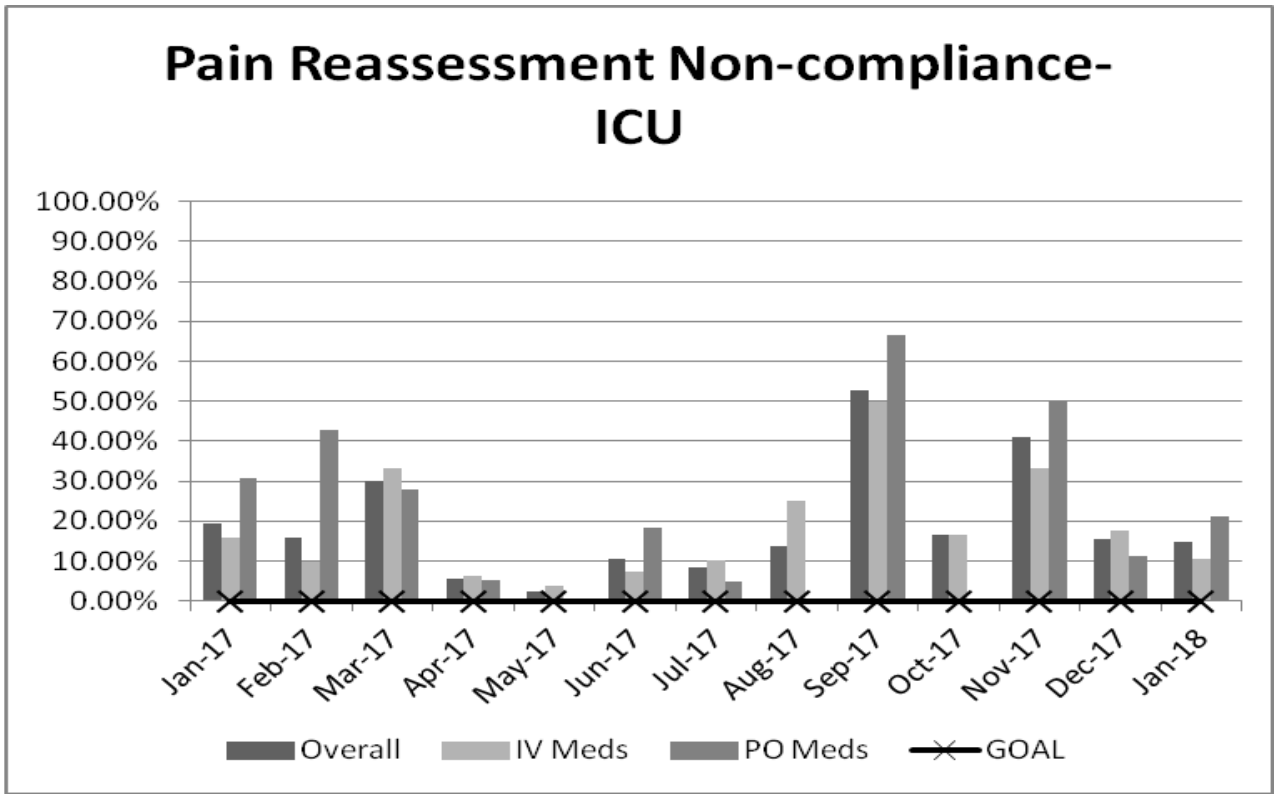


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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.

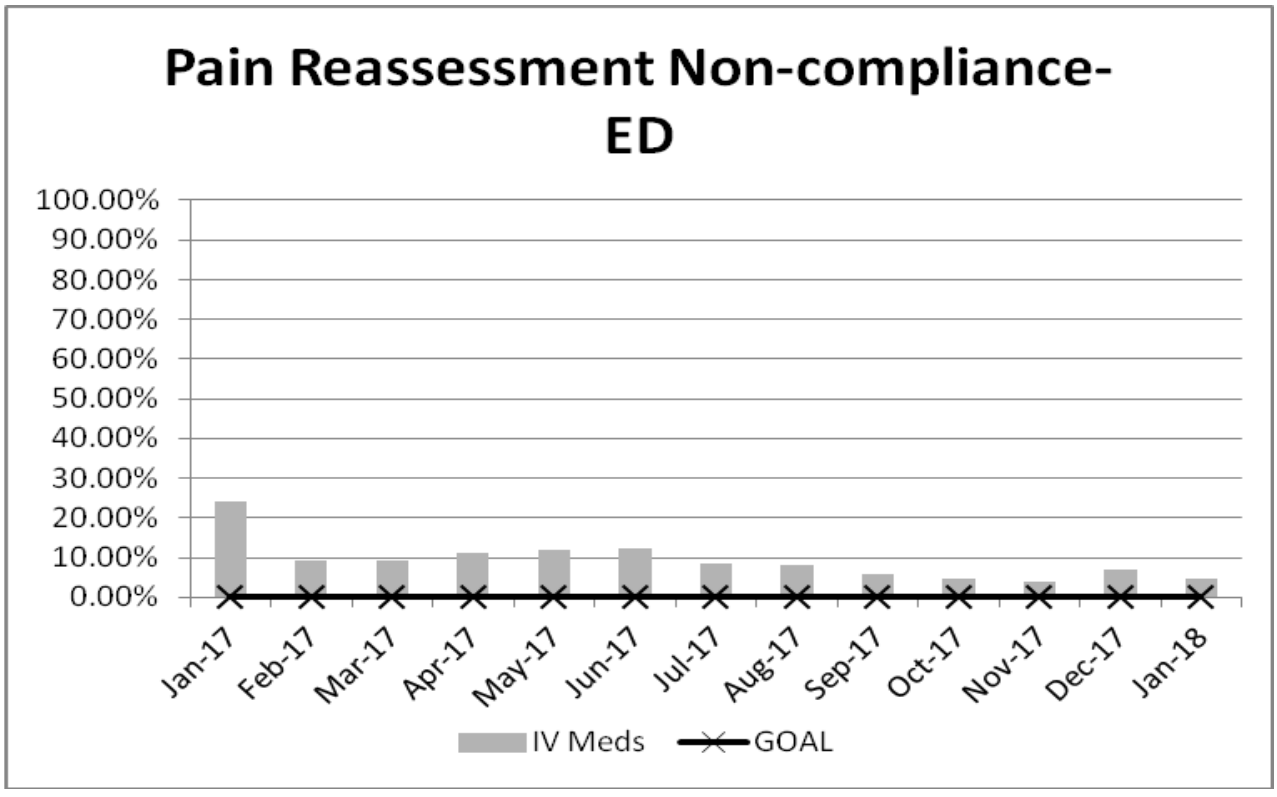


Table 6. Restraint chart monitoring for legal orders.

	July 2017	***Aug 2017***	***Sept 2017***	***Oct 2017***	***Nov 2017***	***Dec 2017***	***Jan 2018***	***Feb 2018****	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	3/3 (100%)	3/3 (100%)	2/2 (100%)	3/3 (100%)	1/1 (100%)	3/3 (100%)	1/1 (100%)	N/A	100%
Physician signed order within 24 hours	3/3 (100%)	2/3 (66%)	1/2 (50%)	2/3 (66%)	1/1 (100%)	2/3 (66%)	0/1 (0%)	N/A	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	3/3 (100%)	1/3 (33%)	0/2 (0%)	2/3 (66%)	1/1 (100%)	1/3 (33%)	0/1 (0%)	N/A	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	2/5 (40%)	2/8 (25%)	0/2 (0%)	1/2 (50%)	N/A	2/6 (33%)	N/A	N/A	100%
Orders are for 24 hours	8/8 (100%)	11/11 (100%)	4/4 (100%)	5/5 (100%)	1/1 (100%)	9/9 (100%)	1/1 (100%)	N/A	100%
Is this a PRN (as needed) Order	0/8 (0%)	0/11 (0%)	0/4 (0%)	0/5 (0%)	0/1 (0%)	0/9 (0%)	0/1 (0%)	N/A	0%

*indicates no patients in restraints for this time period

POLICIES TO THE BOD
ENVIRONMENTAL SERVICES

	POLICY & PROCEDURES TO THE BOARD	MAR, 2018			
	EVS DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Agents: Cleaning Solutions	3/21/2018			
2	Cleaning Agents: Disposal of Cleaning Agents	3/21/2018			
3	Cleaning Agents: Identifying and Labeling Cleaning Agents	3/21/2018			
4	Cleaning Agents: Selection, Measurement, and Use of Cleaning Agents	3/21/2018			
5	Cleaning Procedure: Patient Room Daily and at Discharge	3/21/2018			
6	Cleaning Procedures: Clinical Support Areas: Clinical Support & Ancillary Service Areas	3/21/2018			
7	Cleaning Procedures: Clinical Support Areas: Dietary Dept.	3/21/2018			
8	Cleaning Procedures: Clinical Support Areas: Pharmacy	3/21/2018			
9	Cleaning Procedures: Clinical Support Areas: Protocol for Clinical Laboratory	3/21/2018			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD	FEB, 2018			
	PHARMACY DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Black Box Warnings	2/21/2018			
2	Automated Dispensing Unit	2/21/2018			
3	Automatic Stop of Medication Orders	2/21/2018			
4	Discharge Medications	2/21/2018			
5	Drug Orders	2/21/2018			

Title (Version)
Admission Assessment of Obstetrical Patient* (v.4)
Admission Procedure and Care of Newborn* (v.6)
Bili-Lite Pad Olympic (v.2)
BiliChek Transcutaneous Bilirubin Testing (v.5)
Breastfeeding the Term Infant* (v.4)
Certified Nurse Midwife-Stardardized Procedures (v.2)
Cervical Culture Procedure (v.2)
Cesarean Delivery* (v.3)
Childbirth Photography/Videotaping* (v.2)
Consent for Induction or Augmentation of Labor (v.1)
Cord Blood Procedures (v.2)
Delivery Packs and Instruments (v.3)
Emergency Medication Boxes in Perinatal Unit (v.2)
Epidural Anesthesia: Management of the Laboring Patient* (v.4)
Epidural PCA for Obstetric Analgesic Services (v.2)
Fall Risk Prevention - Perinatal* (v.1)
Fetal Fibronectin Testing (v.3)
Fetal Heart Rate Monitoring when not in the OB Unit (v.3)
Fetal Monitoring Internal (v.2)
Hearing Screening Program Newborn (v.4)
Hepatitis B Vaccination of Newborns (v.3)
High Risk OB Patients (v.2)
HIV Prevention Program Perinatal (v.3)
Infant Formula Preparation and Storage (v.2)
Infection Control Policy Perinatal* (v.4)
Intubation of an Infant (v.2)
Isolette Policy and Procedure (v.2)
LDRP Delivery (v.2)
Meconium Delivery (v.2)
Medical Screening Exam for the Obstetrical Patient - Standardized Procedure (v.2)
Misoprostol for Cervical Ripening* (v.4)
Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure (v.3)
Neonatal Intravenous Therapy: Initiation and Management (v.4)
Neonatal Resuscitation/Neonatal Code (v.2)
Newborn Blood Glucose Monitoring* (v.7)
Newborn Discharge Procedure (v.3)
Newborn Hearing Policy (v.3)
Newborn Pulse Oximetry Screen (v.1)
Newborn Screening Test (v.3)
Newborn Transport to XRay Department (v.3)
Nitrous Oxide Use in the Intrapartum/Immediate Postpartum Period* (v.2)
Overflow Placement of Perinatal Patients (v.1)
Perinatal Outpatient Evaluation & Management Level of Care Worksheet* (v.1)
Phototherapy (v.3)
Pitocin Administration* (v.5)
Placenta Disposal (v.3)
Postpartum Hemorrhage Policy (v.2)
Postpartum Patient after Vaginal Delivery Care of (v.3)
Postpartum Recovery (v.3)
Pre-Eclamptic and /or Eclamptic Patient Care of (v.2)
Premature and/or High Risk Infant Care of (v.2)
Premature Infant with Order for "No Code" Care of (v.2)
Prophylactic Eye Treatment for the Newborn (v.2)
Prophylactic Eye Treatment of Infant Refusal (v.1)
Rhogam Administration (v.3)

Rooming In Protocol (v.3)
Safety Policy for Perinatal Unit Patients (v.3)
Shoulder Dystocia* (v.3)
Staffing Guidelines Perinatal Unit Including High Risk (v.2)
Standards of Care- The NEST (v.1)
Standards of Patient Care in the Perinatal Unit (v.3)
Standards of Practice- The NEST (v.1)
Standing Orders For Newborn Nursery (v.1)
Sterile Speculum Exam (v.2)
Sterile Vaginal Examination on Patients with Premature Rupture of Membranes and/or Premature Labor (v.3)
Support Person for the Obstetrical Patient in the Birthing and Operating Rooms (v.3)
Surfactant (exogenous) Therapy in Preterm Infants (v.2)
Telephone Triage* (v.1)
Ultrasound in the Perinatal Unit (v.2)
Unassigned Obstetrical Patients Policy (v.2)
Urinary Catheterization Neonate (v.2)
Vaginal Birth After a Cesarean Section (VBAC) (v.2)
Vaginal Culture Procedure (v.2)
Vaginal Delivery in the OR (v.2)
Vaginal Prep (v.2)
Vitamin K (Phytonadione) Administration (v.2)

Title (Version)
Language Access Services Policy (v.7)
Language Access Services Program* (v.1)

COMPLIANCE DEPARTMENT

POLICY AND PROCEDURE ANNUAL APPROVALS

MARCH 2018

1. Non-Discrimination Policy

CALL TO ORDER	The meeting was called to order at 5:30 pm by John Ungersma MD, President.
PRESENT	John Ungersma MD, President M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Peter Watercott, Member at Large Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Richard Meredick MD, Chief of Staff Sandy Blumberg, Executive Assistant
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. Kevin S. Flanigan, MD, MBA, Chief Executive Officer of Northern Inyo Healthcare District (NIHD) recognized Hilke and John Ungersma, MD for their generous donation of a Galen Rowell print to the Healthcare District. The print is currently on display in the NIHD Board Room. No other comments were heard.
NEW BUSINESS	
BUDGET PROCESS DISCUSSION	Chief Financial Officer John Tremble provided the 2nd in a series of two presentations on a (new) proposed budget process for the 2019 fiscal year. The proposed process allows for budgeting in a manner that ensures the District's Mission, Vision, and Strategic Goals are supported financially by the budgeting process. During discussion on this topic the Board of Directors expressed their desire to have 90 days cash on hand and a net margin goal of not less than .5 percent at the time of the District's Athena Health Information System implementation.
UROLOGY EQUIPMENT PURCHASE	Doctor Flanigan called attention to an unbudgeted Capital and Operating Expense Request to purchase Urology equipment and supplies for start-up of the Districts new Urology service, at an approximate cost of $377,000 (negotiated down from over $550,000). Following brief discussion on the importance of providing urology services for this community it was moved by Peter Watercott, seconded by Jean Turner, and unanimously passed to approve the purchase of urology equipment and supplies as requested.
RADIOLOGY SERVICES AGREEMENT	Doctor Flanigan also called attention to a proposed *Radiology Services Agreement* with Tahoe Carson Radiology that would become effective on

April 1 2018. It was noted that the proposed agreement does not include mammography and pain management services and that the District already has existing agreements for those services in place. It was moved by Mary Mae Kilpatrick, seconded by Mr. Watercott, and unanimously passed to approve the proposed *Radiology Services Agreement* with Tahoe Carson Radiology as presented, with a notation being made that a correction will be made to the name of the Medical Director of Radiology Services listed in the agreement.

IT COUNCIL CHARTER; PROJECT REVIEW BOARD CHARTER; ITS CHANGE ADVISORY BOARD CHARTER

Doctor Flanigan called attention to the following (proposed) NIHD Charters:

- *Information Technology Council Charter*
- *NIHD Project Review Board Charter*
- *NIHD ITS Change Advisory Board Charter*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner and unanimously passed to approve all three charters as presented.

REMOTE ACCESS POLICY

Information Technology Services Director Robin Cassidy called attention to a proposed *Remote Access Policy* which defines the standards for connecting to the NIHD network from any area outside of the District's physical location. It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve the *Remote Access Policy* as presented.

CODE OF BUSINESS ETHICS AND CONDUCT; AND FAMILY MEMBERS IN THE WORKPLACE POLICY

Compliance Officer Patty Dickson called attention to proposed updates of the NIHD *Code of Business Ethics and Conduct;* and the *Family Member and Relatives in the Workplace* Policy and Procedure, noting both documents have been updated to make them more uniform and to include additional best practices. It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve the updated *Code of Business Ethics and Conduct*, and the *Family Member and Relatives in the Workplace* Policy and Procedure as presented.

AUDITING OF EMPLOYEE ACCESS TO PATIENT INFORMATION POLICY AND PROCEDURE

Ms. Dickson also noted that the proposed (updated) Policy and Procedure titled *Auditing of Employee Access to Patient Information* will be tabled to a future meeting, in order to allow time to receive additional input on its content from the NIHD Compliance Committee.

QUARTERLY COMPLIANCE REPORT

Ms. Dickson also called attention to a Compliance Program quarterly report as of February 2018, which included the following:

- Breaches for calendar years 2017 and 2018
- A report on the number of issue and inquiry requests
- Review of Audit reports
- Completion rate for staff Conflict of Interest questionnaires
- CPRA Requests

It was moved by Mr. Watercott, seconded by Ms. Hubbard, and unanimously passed to approve the Compliance Program quarterly report as presented.

SCOPE OF SERVICE, PERINATAL, AND ORIENTATION COMPETENCY COMMITTEE CHARTER

Chief Nursing Officer Tracy Aspel, RN called attention to the following:

- *Scope of Service, Perinatal* Policy and Procedure
- Orientation Competency Committee (OCC) Charter

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve both the *Scope of Service, Perinatal* Policy and Procedure and the OCC Charter as presented.

LEADERSHIP RESTRUCTURE / ORGANIZATIONAL REFOCUS

Doctor Flanigan reported District leadership meetings have been restructured in order to increase focus on achieving the goals of NIHD's Strategic Plan. The Executive Team now meets with designated department managers, coordinators, and staff on a weekly basis in order to focus on the work and goals of Patient Experience and Workforce Experience Committees, as well as a newly created Fiscal Health and Market Share focus group, and a Quality Improvement/Project Management focus group.

OLD BUSINESS

ATHENA IMPLEMENTATION

Updates on implementation of the Athena Health Information System will be provided on a bi-monthly basis going forward, with the next update being presented at the March regular Board of Directors meeting.

PHYSICIAN RECRUITMENT UPDATE

Doctor Flanigan reported the District diligently continues its recruitment for internal medicine and family practice providers. He additionally reported that after three years of effort a full-time pediatrician will be joining the practice of Charlotte Helvie, MD.

CONSENT AGENDA

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

- *Approval of minutes of the January 17 2018 regular meeting*
- *Approval of minutes of the January 25 2018 special meeting*
- *Financial and Statistical reports for November 2017*
- *Financial and Statistical reports for December 2017*
- *2013 CMS Survey Validation Monitoring*
- *Policy and Procedure annual approvals*

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

CHIEF OF STAFF REPORT

Chief of Staff Richard Meredick MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following hospital wide Policies, Procedures, Protocols, and Order Sets:

POLICIES, PROCEDURES, PROTOCOLS,ORDER SETS

- *Accutest Rapid Mono Test*
- *Admission, Care, Discharge and Transfer of the Newborn*
- *Admission, Transfer, and Discharge Care of the Obstetrical Patient*
- *Aids/HIV Testing and Orders*
- *Anesthesia Clinical Standards and Professional Conduct*
- *Cardiac Arrest in the OR*

- *Chemotherapeutic Agents in the OR*
- *Code Blue Documentation*
- *Emergency Medical Screening of Patients on Hospital Property*
- *Entering and ED Admission*
- *HIV Testing Without Consents*
- *In-House Transport of Ventilator Dependent Patients*
- *Newborn Hearing Screening Program*
- *Observation in the Operating Room*
- *Organization-Wide Assessment and Reassessment of Patients*
- *Patient Visitation Rights*
- *Pre and Post Operative Anesthesia Visits*
- *Standard of Care – The NEST*
- *Standard of Patient Care in the Perinatal Unit*

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve all (nineteen) Policies, Procedures, Protocols, and Order Sets as presented.

ANNUAL APPROVALS

Doctor Meredick also called attention to the following annual approvals:

- *ER Service Critical Indicators*
- *Medicine / Intensive Care Service Critical Indicators*

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve both annual approvals as presented.

ADVENTIST HEALTH FORM

Doctor Meredick called attention to a proposed *Complaints and Adverse Events* reporting form for Adventist Health telemedicine providers. It was moved by Mr. Watercott, seconded by Ms. Hubbard, and unanimously passed to approve the *Complaints and Adverse Events* reporting form as presented.

INTERNAL MEDICINE CORE PRIVILEGE FORM

Doctor Meredick also called attention to a revised *Internal Medicine Core Privilege Form*. It was moved by Mr. Watercott, seconded by Ms. Turner, and unanimously passed to approve the revised *Internal Medicine Core Privilege Form* as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVILEGES

Doctor Meredick additionally requested approval of the following Medical Staff appointments and privileging:

- Robert Nathan Slotnick, MD (perinatology) – *Provisional Consulting Staff*
- Michael H. Abdulian, MD (orthopedic surgery, Adventist Health) – *Provisional Consulting Staff*
- Sarkis Kiramijyan, MD (interventional cardiology, Adventist Health) – *Provisional Consulting Staff*
- Sun I. Kim, MD (urology) – *Provisional Consulting Staff*
- Erik J. Maki, MD (radiology, Tahoe Carson Radiology) – *Consulting Staff*
- John Y. Erogul, MD (radiology, Tahoe Carson Radiology) – *Consulting Staff*
- Edmund P. Pillsbury III, MD (radiology, Tahoe Carson

Radiology) – *Consulting Staff*

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all Medical Staff appointments and privileging as requested, with the exception of Michael H. Abdulian MD whose name was withdrawn due to the fact that the Medical Staff recently learned it is likely that he will no longer be coming on board.

TELEMEDICINE STAFF APPOINTMENTS AND PRIVILEGES

Dr. Meredick also stated as per the approved *Telemedicine Physician Credentialing and Privileging Agreement*, and as outlined and allowed by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions:

- Talha Khawar, MD (*rheumatology, Adventist Health*) – Telemedicine Staff
- Leon Kujmanian, MD (*endocrinology, Adventist Health*) – Telemedicine Staff

It was moved by Ms. Hubbard, seconded by Mr. Watercott, and unanimously passed to approve the Telemedicine appointments and privileges as requested.

MEDICAL STAFF RESIGNATIONS

Doctor Meredick also called attention to the following Medical Staff resignations (Bishop Radiology Group physicians):

- Arash Radparvar, MD – effective 2/12/18
- Young Song, MD – effective 2/12/18
- William I. Feske, MD – effective 2/12/18
- Eric W. Wallace, MD – effective 2/12/18
- David Y. Kim, MD – effective 3/22/18

It was moved by Mr. Watercott, seconded by Ms. Hubbard, and unanimously passed to approve all five Medical Staff resignations as requested.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to report on any items of interest. Director Hubbard mentioned that the last review of NIHD District Bylaws took place in 2015, and she suggested that it may be time to review them again. It was decided that Directors Hubbard and Ungersma will meet to conduct an initial review of the District's current Bylaws, then a review by the full Board will be placed on the agenda for a future meeting. Ms. Hubbard additionally stated her desire for the full Board to review the comments section of the January 2018 Board Self Assessment, and it was determined that those comments will be reviewed during an upcoming Board Retreat that will be scheduled in the near future. Director Turner commented that she felt the Association of California Healthcare Districts (ACHD) February leadership meeting was very worthwhile, noting that she would like this Board to discuss stakeholder engagement and review additional data provided at the ACHD meeting. Director Kilpatrick reported that the NIHD Foundation has agreed to fund an upgrade and further development

of the NIHD website, pending receipt of a formal cost analysis. No other comments were heard.

CLOSED SESSION

At 7:26 pm Doctor Ungersma announced the meeting would adjourn to closed session to allow the Board of Directors to:

A. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation, 2 matters pending (*pursuant to Government Code Section 54956.9*).
B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
C. Discuss a real estate negotiation (*pursuant to Government Code Section 54956.8*).
D. Discuss a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:53 pm the meeting returned to open session. Dr. Ungersma reported that the Board voted to reject a real estate counter offer.

ADJOURNMENT

The meeting adjourned at 8:54 pm.

_____
John Ungersma MD, President

Attest:

_____
Mary Mae Kilpatrick, Secretary

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

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

TO: NIHD Board of Directors
FROM: Richard Meredick, MD, Chief of Medical Staff
DATE: March 6, 2018
RE: Medical Executive Committee Report

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

A. Policies/Procedures/Protocols/Order Sets (*action items*)
    1. *Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)*
    2. *Collection of Aerobic and Anaerobic Cultures*
    3. *Emergency Care Policy for Emergency Department Physician Assistant – Standardized Procedure*
    4. *General Policy for Emergency Department Physician Assistant – Standardized Procedure*
    5. *Intimate Partner Abuses Guidelines, for Victims of*
    6. *Intravenous to Oral Route of Administration Opioid Conversion Protocol – Inpatient Adult*
    7. *Medication/Device Policy for Emergency Department Physician Assistant – Standardized Procedure*
    8. *Multidrug Resistant Organism (MDRO) Control Plan*
    9. *N95 Mask Fit Testing Using PortaCount Pro*
    10. *Opening and Closing Nursing Departments*
    11. *Standards of Care in the ICU*
    12. *Warfarin Protocol – Inpatient Adult*

B. Annual Approvals (*action items*)
    1. Utilization Review Critical Indicators
    2. Pediatric Critical Indicators
    3. Standardized Procedures and Protocols
        i. *RN First Assistant*
        ii. *Medical Screening Examination of the Obstetrical Patient*
        iii. *CNM First Assist During Cesarean Sections*
        iv. *Physician Assistant in the OR*

C. Medical Staff Advancements (*action item*)
    1. Uttama Sharma, MD (*family medicine*) – Dr. Sharma has undergone 50+ chart reviews and direct supervision Thu-Sat x 4 months by her proctor, Dr. Stacey Brown since her appointment in August 2017. Dr. Brown is happy to report Dr. Sharma has completed her focused professional practice evaluation (FPPE) and is recommending her for advancement from provisional staff to full active staff at NIHD.

D. Medical Staff Appointments/Privileges (*action items*)

1. *The following applicants have undergone full credentialing and have been recommended for appointment to the Medical Staff by the Credentials and Medical Executive Committees in the appropriate category.*

Name	Specialty	Category
Michael H. Abdulian, MD	Orthopedic Surgery	Provisional consulting staff
David B. Huddleston, MD	General Surgery	Provisional active staff
Kristin Irmiter, MD	Pediatrics	Provisional active staff
Daniel Firer, MD	Family Medicine *(Emergency Department)*	Provisional active staff
Sandra Althaus, MD *Tahoe Carson Radiology*	Interventional Radiology	Consulting staff
Ryan Berecky, MD *Tahoe Carson Radiology*	Neuroradiology	Consulting staff
Nicholas Carlevato, MD *Tahoe Carson Radiology*	Interventional Radiology	Consulting staff
David Landis, MD *Tahoe Carson Radiology*	Diagnostic Radiology	Locum tenens
Stephen Loos, MD *Tahoe Carson Radiology*	Diagnostic Radiology	Active staff
Keith Shonnard, MD *Tahoe Carson Radiology*	Interventional Radiology	Consulting staff
Gary Tuner, MD *Tahoe Carson Radiology*	Neuroradiology	Consulting staff

E. Telemedicine Staff Appointment/Privileges – credentialing by proxy (*action items*)

1. *As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions.*

Name and Specialty	Distant Site	Category
Azadeh Majlessi, MD (rheumatology)	Adventist Health (Glendale)	Telemedicine staff
Nilem Patel, MD (endocrinology)	Adventist Health (Glendale)	Telemedicine staff

F. Temporary Locum Tenens Privileges (*action item*)

1. *The following physician has undergone the full credentialing process and has been recommended for temporary/locum tenens privileges for up to 60 days in 2018, unless extended and approved for good cause:*

Name	Specialty	Category
Arsen Mkrtchyan, MD	Internal Medicine *(hospitalist)*	Temporary/locum tenens *Up to 60 days in 2018*

G. Additional Privileges – Allied Health Professionals (*action item*)

1. *The following Allied Health Professional has applied for privileges in the Emergency Department. In times of heavy patient volume, the ED physician on duty may call upon the applicant to assist with patient care. The applicant will be working under approved Standardized Protocols and will undergo an initial period of monitoring.*

Name and Specialty	Location of Service	Category
Jennifer Figueroa, PA-C	Emergency Department	Allied Health Professional

H. Change in Staff Category (*action item*)

1. Edmund P. Pillsbury III, MD (*radiology*) – application for change in staff category from consulting staff to active staff

PURPOSE:
To give Environmental Services (EVS) personnel the proper guidelines and training to ensure proper cleaning and disinfecting of the Pharmacy Sterile IV Preparation area (Clean Room).

POLICY:
1. Monthly use an EPA-registered sporicidal detergent to clean. This will occur on the first Saturday of the month.
2. Daily cleaning will be completed using an EPA and NIH approved germicidal product ex: Quat detergent. Alcohol has no detergent properties, so is unacceptable for this purpose
3. Designated cleaning equipment must be used when cleaning Pharmacy Sterile IV Preparation area.
4. Disposable mops are preferred. Reusable mops may be acceptable if they are laundered to clean room standards.
5. Personal Protective Equipment (PPE) must be applied prior to entering Pharmacy Clean Room and removed when exiting.
6. A daily cleaning and a monthly log must be posted inside of pharmacy this will be completed by EVS staff.
7. Every EVS attendant must be trained upon hire and annually if they are responsible for cleaning the Pharmacy Sterile IV Preparation area. Documentation of training will be located in Pharmacy and in the employee file.
8. Cleaning of Pharmacy Sterile IV Preparation area (Clean Room will occur when there are no compounding activities being performed.
9. Makeup, nail polish, and artificial nails ***are prohibited*** in Pharmacy Sterile IV Area (clean room). Per CCR section 1751.5 (a) (6).
10. No food, drinks, gum, or candy allowed in the clean room.

PROCEDURE:
1. Perform Hand Hygiene
2. Don Proper Personal Protective Equipment prior to entering clean room (Gown, mask, gloves, hairnet, booties, and eye protection). Remove and discard PPE when exiting.
3. Daily clean- wipe all horizontal surfaces, mop the floor with a designated mop and wipe the plastic curtains inside and out using EPA germicidal agent.
4. Monthly cleaning-Walls, ceilings, storage shelving, tables, stools, and all other items and surfaces in the Pharmacy Clean Room using approved sporicidal.
5. No sweeping, dusting or spraying will be done while in Pharmacy Clean Room.
6. Daily empty all trash containers. The outside of the waste containers shall be wiped out with the approved germicidal cleaning and disinfecting solutions.
7. Monthly cleaning of the inside and outside of trash containers will be wiped down with approved sporicidal agent.
8. All waste containers will be properly disposed of when at fill line.
9. Complete daily and monthly log.

REFERENCES:

1. Barclays Official California Code of Regulations. (2017). § 1751.4. Facility and Equipment Standards for Sterile Compounding. 16 CA ADC § 1751.4. Retrieved from https://govt.westlaw.com/calregs/Document/IAAFDB08F68244EACA20CE143EFB97751?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1
2. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
3. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
4. California Board of Pharmacy (2017). Compounding Regulations Guidance: Title CCR section 1735 et seq. and CCR section 1751 et seq. Retrieved from http://www.pharmacy.ca.gov/publications/compounding_faqs.pdf

CROSS REFERENCE P&P:

1. **Materials Waste Management Plan**

Approval	**Date**
CCOC	1/29/18
P&T	2/15/18
Infection Control Committee	2/27/18
MEC	3/6/18
Board of Directors	
Last Board of Directors Review	

Developed: 11/16 AS
Reviewed:
Revised: 12/14/2017 AS/RC
Supersedes:
Index Listings: Clean room, Compounding

PURPOSE

To provide a method of collecting specimens to determine if bacterial/viral growth is present while minimizing contaminants within the operating suites.

POLICY

The following procedure will be followed while collecting aerobic or anaerobic cultures in the operating room.

EQUIPMENT

- Anaerobic vacutainer specimen collector.
- Culturette with aerobic collection and transport system.

PROCEDURE

Aerobic/Anaerobic Cultures:

- Open package according to sterile procedure by peeling open package and allowing scrub person to take culturette.
- Remove cap/swab from tube.
- Take sample and return cap/swab to tube. .
- Push cap down to assure that swab is immersed in the gel at the bottom of tube.
- Return to lab immediately.

Collection of liquid or purulent specimens:

- Collect specimen with syringe and needle. Air trapped in syringe should be expelled by holding syringe and needle upright. Expel air at tip of syringe into alcohol saturated sponge.
- Remove swab/plunger unit and expel material into inner tube. Proceed as above for either aerobic or anaerobic cultures.

Collection of tissue specimens:

- Transport tissue specimen in a **clean sterile container (screw capped container preferred)** to lab immediately to avoid specimen from drying out. DO NOT ADD FORMALIN TO THE SPECIMEN FOR MICROBIOLOGY CULTURES. Specimens received in the lab in formalin for culture will be rejected.

Safe Transport and handling of specimens:

- Cultures should be sent to the laboratory immediately. During work hours until 2300, use push to talk phone and contact laboratory personnel, they will pick up culture for transport to laboratory. After 2300, call laboratory phone # and personnel on call will come and pick up the culture.
- The circulating nurse can hold open a plastic bio-hazard bag for the scrub person to drop the vacutainer or culturette into.
- The culture containers are not to be handled by the circulating personnel unless gloved.
- All specimens will be transported in a plastic bio-hazard bags provided for by the lab and will be properly labeled with patient identification and source of specimen. Surgery will use a uniquely colored bag for specimen transport. This will alert Laboratory Personnel that the specimen is a

surgical specimen. If an electronic order is not found, Laboratory Personnel will alert the Surgery Coordinator or Charge Nurse, the coordinator or charge nurse will ensure an electronic order is placed.

- Document in patients chart the physician's order, culture sites and type and time obtained.

For AFB (TB):

- Call laboratory prior to obtaining specimen and confirm use of sterile container or culturette swab for type of specimen being collected.

DOCUMENTATION:

- The circulating RN must document culture information on operating room record, and submit an electronic order for each specimen collected.

Approval	**Date**
CCOC	11/6/17
STTA	1/24/18
Med Services/ICU Committee	2/14/18
Medical Executive Committee	3/6/18
Board of Directors	
Last Board of Directors Review	

Index Listings: Cultures In Operating Room
Revised 02/01 1-2010 Bs, 11/17 AW
Reviewed 02/2011BS, 9/17 AW
Last Board of Director review: 1/18/17

POLICY:

1. Definition: Physician Assistant is licensed by the State of California Department of Consumer Affairs and possesses preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in emergency care, and who has been prepared in a program that conforms to board standards.

2. Development and Review
    a. All Physician Assistant Protocols are developed collaboratively and approved by the Northern Inyo Healthcare District (NIHD) Interdisciplinary Practice Committee (IDPC) and must conform to Title 16, Chapter 7.7, section 3502.
    b. All Physician Assistant Protocols will be kept in a manual that includes date and signature of the Physician Assistant who is approved under the protocol and the Physician Supervisor(s).
    c. All Emergency Department Physician Assistant Protocols are to be reviewed every 3 years at minimum by the PA(s), Chief of Emergency Room Service, and then by the IDPC. Standardized procedures will be updated as practice changes.
    d. All changes or additions to the Protocols are to be approved by the IDPC. All Protocols approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIHD Board of Directors.

3. Setting of Practice: NIHD Emergency Department (ED)

4. Scope of Practice
    a. The PA may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of patients presenting to the emergency department (including but not limited to ordering laboratory procedures, x-rays, EKGs, and referring to or consulting specialty services when indicated).
    b. Protocol functions, such as prescribing medications, are to be performed at NIHD ED. Consulting Supervising Physician(s) will be available to the PA(s) in person.
    c. Physician consultation is to be obtained under the following circumstances:
        i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
        ii. Acute decompensation of patient situation.
        iii. Problem which is not resolving as anticipated.
        iv. History, physical, or lab finding inconsistent with the clinical picture.
        v. Upon request of patient, nurse, or supervising physician.
    d. Medical Records:
        i. Medical record entries by the PA shall include, for all problems addressed: the patients' statement of symptoms, the physical findings, results of special studies,

the PA's assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.

ii. Each time a PA provides care for a patient and enters his or her name, signature, initials or computer code on a patient's record, chart or written order, the PA shall also enter the name of his or her supervising physician who is responsible for the patient (as specified in CA Code of Regulations 1399.546.)

5. Qualifications and Evaluations
   a. Each Physician Assistant performing PA Protocol functions must have a current California Physician Assistant license, be a graduate of an approved Physician Assistant program, and have current certification as a Physician Assistant by the California Physician Assistant Committee and the Department of Consumer Affairs.
   b. Evaluation of PA's competence in performance of Protocol functions will be done in the following manner:
      i. Initial: Within the initial training period the Supervising Physician(s) will evaluate performance via direct observation, consultations and chart review/co-signature and provide feedback to the Interim PA. Input from other physicians and colleagues will be utilized. Recommendations to move from Interim status to full status will be considered. ED Nurse Manager along with the Medical Director will provide feedback utilizing performance evaluation based upon the PA job description.
      ii. Routine: annually after the first year by the Supervising Physician/Medical Director through feedback from the physicians, colleagues and charting review. This will be addressed during the annual performance evaluation.
      iii. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the NIHD ED Medical Director at appropriate intervals until acceptable skill level is achieved.
   c. The scope of supervision for the performance of the functions referred to in this area shall include chart review as per the Delegation of Services Agreement.
   d. Further requirements shall be regular continuing education in emergency or other relevant medical care, including reading of appropriate journals and new text books, attending conferences sponsored by hospitals, professional societies, and teaching institutions equaling 15 hours a year, minimum.
      i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing.

ii. Continuing education information will remain on file in the PA's competency notebook. A copy of the competency assurance documents will be submitted to Human Resources at the end of each calendar year to be stored in the PA's HR file.

6. Protocols
    a. The Emergency Care Policy for Emergency Department Physician Assistant is designed to describe the steps of medical care for care of patient presenting to the emergency department.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

CROSS REFERENCE P&P:

1. Emergency Care Policy for Emergency Department Physician
2. Medication/Device Policy for Emergency Department Physician Assistant

Approval	**Date**
Interdisciplinary Practice Committee	2/28/18
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Developed: 2/2018 sb
Reviewed:
Revised: 2/2018 dp
Supersedes:
Index Listings:

POLICY:

1. Will meet General Policy - Protocol guidelines as described in the General Policy Component.
2. Circumstances:
    a. Patient population: pediatric and adult patients
    b. Setting: Northern Inyo Healthcare District Emergency Department (NIHD ED)
    c. Supervision: Physicians indicated in Delegation of Services Agreement

PROTOCOL:

1. Definition: this protocol covers the management of Emergency Care conditions which may present to the NIHD Emergency Department.
2. Database
    a. Subjective
        i. Obtain pertinent history related to emergency symptoms
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective
        i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and imaging studies.
3. Assessment
    a. Formulate diagnosis consistent with the data base collected.
    b. Document diagnosis in the patient chart
4. Treatment Plan – medical regimen
    a. Patients requiring emergency care will be stabilized to the best of the capabilities of the NIHD ED. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist for inpatient care or to accepting outside physician if transfer to another facility is warranted.
    b. The Physician assistant(s) may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
        i. Establishing and maintaining an airway
        ii. Cardiopulmonary resuscitation
        iii. Control of hemorrhage by external pressure or tourniquet
        iv. Establishing an intravenous line
        v. Injection of epinephrine for asthma, anaphylactic shock or laryngeal edema
        vi. Administration of oxygen for acute dyspnea
        vii. Splint or reduce skeletal injuries

viii. Incision and drainage of abscesses
ix. Irrigate and repair wounds
x. Apply heat or cold for exposure
xi. Administration of Narcan for suspected narcotic overdose
xii. Administration of intravenous glucose for suspected hypoglycemia
xiii. Follow Advanced Cardiac Life Support Guidelines

c. Physician Consultation: As described in the General Policy Standardized Protocol.
d. Consult specialty physician or transfer care of patient.
e. Refer to Physician or Specialty Clinic: Diagnosis and/or treatment are beyond the scope of the PA's knowledge and/or skills, or for those conditions that require consultation.
    i. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.
f. Medications – see Delegation of Services Agreement and Medication/Device Policy for Emergency Department Physician Assistant

5. Documentation
    a. All emergency care provided will be recorded in the ED patient chart.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

CROSS REFERENCE P&P:

1. General Policy for Emergency Department Physician Assistant
2. Medication/Device Policy for Emergency Department Physician Assistant
3. EMTALA Policy

Approval	**Date**
Interdisciplinary Practice Committee	2/28/18
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Developed: 2/2018 sb
Reviewed:
Revised: 2/2018 dp
Supersedes:
Index Listings:

PURPOSE:

1. To identify any conditions resulting from abuse by a spouse or partner and to insure appropriate referrals and treatment.
2. To insure compliance with local law enforcement and regulatory compliance for reporting of actual or suspected abuse cases.
3. To facilitate protective care of suspected or abused spouses/partners.
4. Any licensed healthcare practitioner employed or providing services to a patient at NIHD who has suspicion or actual knowledge of physical or emotional abuse by a spouse/partner is mandated to make a report to the local law enforcement agency in which the incident occurred.
5. No information regarding the patient's whereabouts after discharge will be released.
6. Maintenance of concise, accurate records.

POLICY:

1. Domestic violence protocol shall be utilized for assisting the battered woman/man/spouse/partner. Staff needs to be aware that victims of Intimate Partner violence may present in any department within the District.

PROCEDURE:

1. Appropriate medical care will be rendered for the injuries sustained or for other medical conditions.
    a. The physician may consider referral for psychological counseling.
    b. Staff should maintain a nonjudgmental attitude toward the patient.
2. Identifying Suspected Abuse
    a. The patient has been seen repeatedly in the ED or clinics.
    b. Hesitance in providing detailed information about the injury.
    c. X-rays/tests show broken bone(s) with no explanation on injury.
    d. Minimization of the importance of the injury when there is evidence of significant harm.
    e. Inappropriate affect, such as depression or increased anxiety with minor injuries.
    f. Other important characteristics of a abuse victim:
        i. Shyness
        ii. Obvious signs of fear
        iii. Embarrassment
        iv. Nervousness
        v. Passivity.
    g. Evidence of repeated injury to face or neck.
    h. Presence of increased anxiety in the presence of suspected batterer.
    i. Looking at suspected batterer for approval before answering questions.
3. Provide a safe, private room.
    a. Separate victim from suspected batterer.
    b. Provide one consistent, supportive caregiver, for example:
        i. MD or RN
        ii. Social Worker
        iii. Mental Health Counselor

iv. Clergy
v. Wild Iris Counselor

c. Remain with the victim at all times.
d. Reassure victim that he/she is safe.
e. Remain non-judgmental, non-threatening, and non-accusatory.
f. Do not pressure victim to give a truthful story.
g. Ask open-ended statements.
h. Do not express shock or dismay that the victim has not taken steps to remove her or himself or children from the situation.
i. Inform victim that caregivers are required to report assault or battery resulting in injury and physical abuse.
j. Allow victim to make his/her own choices regarding immediate plans.

4. Reporting Responsibilities
    a. When it is clear there is a suspicion of intimate partner abuse, the licensed healthcare provider is to telephone the appropriate law enforcement agency for which the incident occurred to file a verbal report.
    b. All licensed clinical staff is accountable for reporting any actual or suspected abuse and will be legally liable for failure to report.
    c. The name of the suspected abused individual and all persons reporting suspected cases shall at all times be confidential and available only to those persons authorized to receive this information.
    d. When to make a report.
        i. If, in the course of the history and assessment, it is determined that the patient's injuries were sustained through the use of a deadly weapon, or through another criminal law violation, a report will be made.
        ii. If the patient verbalizes, at any time, that injuries were sustained as a result of assault or abusive conduct.
    e. Reporting Procedure
        i. After gaining knowledge of suspected or actual abuse, during regular business hours, the healthcare worker will notify the social worker who will assess the patient's situation and when appropriate, may report to law enforcement if not already done.
        ii. The social worker can be contacted during normal business hours if the healthcare provider making the report needs assistance or consultation.
        iii. The House Supervisor will be notified of all suspected abuse cases treated within the hospital. The House Supervisor will be responsible for notifying the appropriate administrator.
        iv. The attending physician will be notified when a report is filed.
        v. When two or more persons who are mandated to report are present and jointly have knowledge of a suspected incident and there is agreement among them, the telephone report may be made by one selected member of the team.
        vi. No employee shall be discharged, suspended, disciplined or harassed for making a report pursuant to mandatory reporting statues or this policy.
5. Documentation
    a. Observations and assessment findings which lead up to the decision to report will be documented in the appropriate areas of the patient's medical record. This should include any statements

regarding the cause of injuries and identify the person alleged to have inflicted the injuries. When quoting, don't paraphrase, write exactly what was said.

b. Document the date and time, verbal report was made to the appropriate law enforcement agency. Include the name and ID number of the person to whom the report was made and the case number, if applicable.
c. The intimate partner abuse report shall include, but not limited to
    i. The name of the injured person
    ii. The injured person's whereabouts
    iii. The identity of any person the injured person alleges inflicted the wound, other injury, or assault/abusive conduct upon the patient.
    iv. Abused person's feelings/safety concerns about report being filed.
d. The medical record is to include:
    i. Comments by the injured person regarding past domestic violence.
    ii. A body-map identifying and locating injuries.
e. The patient is to be offered appropriate community resource information regarding domestic violence, including counseling and shelters.
f. Collection of Evidence
    i. Preserve any physical evidence, such as pieces of glass removed from a wound, torn or blood stained clothing.
    ii. One person should gather all evidence, if possible.
    iii. Place evidence in a bag or envelope, seal and label with the patient's name, date, time, source and the name of the person collecting the evidence.
    iv. Chain of Custody for evidence will be maintained in the following manner.
        1. All evidence collected will be given to the appropriate law enforcement agency.
        2. The employee collecting the evidence will keep it in his/her possession at all times until such time that it is turned over to law enforcement personnel.
        3. When the employee can't maintain possession, the evidence is to be locked up until it is turned over to law enforcement personnel.
        4. Document the relinquishment of evidence and the name and ID number of the officer receiving the evidence.
g. Photo documentation should be attained by the law enforcement agency involved in the case. The healthcare personnel may take photos for the medical records, but these photos may not be admissible in court. Make sure to communicate with law enforcement regarding photographing any injuries. Injuries may include:
    i. Signature bruising
    ii. Burns
    iii. Bite marks
    iv. Lacerations
    v. Abrasions
    vi. Old injuries/scars

6. Discharge Plan
    a. Discharge victim when he/she is able to describe a plan of action and can verify he/she has a safe place to go.
    b. Notify the local law enforcement agencies as appropriate.

c. Patient must sign a consent and/or release of medical records if he/she wants to take photographic evidence home.

REFERENCES:

1. National Coalition Against Domestic Violence (NCADV), www.ncadv.org
2. Increasing identification of domestic violence in emergency departments: A collaborative contribution to increasing the quality of practice of emergency nurses. Contemporary Nurse, 04/2010, Volume 35, Issue 1
3. Assessment of Musculoskeletal Injuries from Domestic Violence in the Emergency Department. Case Reports in Emergency Medicine, 2015, Volume 2015

CROSS REFERENCE P&P:

1. Intimate Partner Abuse Guidelines for Victims of
2. Intimate Partner Abuse Guidelines for Victims of

Approval	**Date**
CCOC	12/4/17
UR	2/22/18
MEC	3/6/18
Board of Directors	
Last Board of Directors Review	6/21/17

Developed: 2/1995
Reviewed:
Revised: 1/2001, 2/2002, 2/15as, 11/17jb
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
Intravenous to Oral Route of Administration Opioid Conversion Protocol
POLICY AND PROCEDURE

Title: Intravenous to Oral Route of Administration Opioid Conversion Protocol – Inpatient Adult	
Scope: Hospital Wide	Manual: Pharmacy
Source: Interim Pharmacy Director	Effective Date: 2/15/18

PURPOSE: The current IV opioid shortages for hydromorphone, fentanyl, morphine, meperidine, and methadone require immediate changes in prescribing patterns. Restrictions have been implemented to conserve available supplies and conversion of IV opioids to oral opioids will be enforced by pharmacy through the following P&T directed protocol.

POLICY: Pharmacists have authority to convert orders using the approved protocol with appropriate documentation in the pharmacist intervention.

PROCEDURE:

1. IV opioids will be restricted to the following patients:
    a. Active nausea and vomiting, partial bowel obstruction, or NGT with suction
    b. Presence of a malabsorptive process
    c. Special circumstances such as sickle cell crisis or pain crisis secondary to malignancy (recommend pain pharmacy consult)
    d. Anesthesia and/or procedural sedation
    e. Patients with acute severe pain on presentation.

All other patients will be converted to oral opioids for pain management. Patients NPO for anesthesia or sedation can continue receiving oral opioids with sips of water. Consider the addition or substitution of non-opioid analgesics (i.e. acetaminophen, ibuprofen, or ketorolac).

We are aware that some patients may express dissatisfaction with their pain regimens and the restrictions. Remind patients and family members that appropriate alternatives are available at Northern Inyo Hospital. National "best practice" guidelines encourage preferential use of oral analgesics as part of an in-patient opioid safety strategy.

Approval	**Date**
P&T Committee	2/15/18
Medical Executive Committee	3/6/18
Board of Directors	
Last Board of Directors Review	

Developed: Nicholas Vu (2/6/18)
Reviewed:
Revised:
Supersedes:
Index Listings:

EQUIANALGESIC TABLE

PO (mg)	Analgesic	IV/IM/SC
30	**Morphine**	10
20	**Hydrocodone**	-
20	**Oxycodone**	--
10	**Oxymorphone**	1
4	**Hydromorphone**	1.5
-	**Fentanyl**	0.1
200	**Codeine**	-
300	**Meperidine**	75

The dosing ratio of fentanyl above applies to acute or opioid naïve dosing

MORPHINE TO METHADONE

EQUIANALGESIC DOSE RATIO (EDR)

Oral Morphine Equivalents	Morphine : Methadone EDR
0 – 100 mg/day	4:1 (i.e., morphine 4 mg = methadone 1 mg)
101 – 300 mg/day	10:1 (i.e., morphine 10 mg = methadone 1 mg)
>301 mg/day	15:1 (i.e. morphine 15 mg = methadone 1 mg)

Methadone to oral morphine equivalent	1:5 (methadone 1 mg = morphine 5 mg)

Methadone PO	Methadone IV
1 mg	0.8 mg

FENTANYL TRANSDERMAL (TD) PATCH CONVERSION

IV	Analgesic	Patch
25 microgram	Fentanyl	25 mcg/hr
1 mg	Morphine	1 mg/hr IV

The conversion ratio above applies to patients on chronic opioid therapy. An easy way to remember the conversion of morphine IV to fentanyl TD is as follows:

- Total amount of IV morphine for 24 hours = dose of the fentanyl transdermal patch per hour.
    - Example: 50 **milligrams** IV morphine over a 24 hour time Period = 50 **micrograms** per hour of fentanyl TD patch

NEURAXIAL MORPHINE CONVERSIONS

PO	IV	Epidural	Intrathecal
30 mg	10 mg	1 mg	0.1 mg

POLICY:

1. Will meet all General Policy - Protocol guidelines.
2. Function: use of specific drug or device
3. Circumstances:
    a. Patient population: Adult/Pediatric patients
    b. Setting: Northern Inyo Healthcare District Emergency Department (NIHD ED)
    c. Supervision: Physicians indicated in Delegation of Services Agreement

PROTOCOL:

1. Definition:
    a. Management of drugs and devices for patients of all ages presenting to the Emergency Department. The Physician Assistant may initiate, alter, discontinue, and renew medication included on the formulary referenced in Appendix A. The adoption of this written, practice-specific formulary is governed under Business and Professions Code, Title 16, §3502.1(a)(2). Schedule I medications are excluded.
2. Data Base:
    a. Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
    b. Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
    c. Assessment: Subjective and objective information consistent for the use of the drug or device.
3. Treatment
    a. Physician assistants may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device per Business and Professions Code, Title 16, §3502.1.(a)
    b. Medications/devices prescribed by the PA may be either over-the-counter or medications/devices requiring a prescription.
    c. Medications/devices may be furnished directly to the patient, or the patient's direct care giver, by the PA.
    d. Physician assistants may only prescribe medication/devices appropriate for use in the type of practice engaged in by the current supervising physician(s) defined in the Delegation of Services Agreement.(Business and Professions Code, Title 16, §3502.1(a)(2))

e. The drug or device will be appropriate to the condition being treated:
    i. Dosage will be in the effective range per formulary references
    ii. Not to exceed upper limit dosage per formulary references.
    iii. Indications or uses as specified by the formulary references.
    iv. No absolute contraindications of the use of the drug or device.
f. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.
g. All medications/devices furnished shall be documented in the patient's medical record. The effectiveness of the medication/device shall also be documented in the patient's medical record.

4. Patient Education:
    a. Provide the client with information and counseling in regard to the medication/device. Caution the client regarding potential side effects or complications with chosen medication/device. Document the education process in the medical record.
5. Physician consultation is to be obtained under the following circumstances:
    a. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    b. Acute decompensation of patient situation.
    c. Problem which is not resolving as anticipated.
    d. History, physical, or lab finding inconsistent with the clinical picture.
    e. Upon request of patient, nurse, or supervising physician.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

CROSS REFERENCE P&P:

1. General Policy for Emergency Department Physician
2. Medication/Device Policy for Emergency Department Physician Assistant

Approval	**Date**
Interdisciplinary Practice Committee	2/28/18
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Developed: 2/2018 sb
Reviewed:
Revised: 2/2018 dp
Supersedes:
Index Listings:

APPENDIX A:

FORMULARY SPECIFICATIONS for
Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant
STANDARDIZED PROCEDURE/PROTOCOL

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

PURPOSE:
To identify and isolate patients infected or colonized with multi-drug resistant organisms (MDRO) to prevent the spread of MDRO infections and Health Care Associated Infections (HAI's) within the hospital.

LEGAL BASIS:
California Senate Bill No. 1058, an act to add Sections 1255.8 and 1288.55 to the Health and Safety Code, relating to Health. This bill establishes the Medical Facility Infection Control and Prevention Act or Nile's Law.

DEFINTIONS:

1. **Colonization:** When organisms are present in or on the body, but not causing any signs or symptoms of an infection.
2. **Direct Contact Transmission:** Direct body surface to body surface contact and physical transfer of bacteria between a susceptible host and an infected or colonized individual (e.g.: touching, contact with oral secretions, or body lesions)
3. **Indirect Contact Transmission:** Contact of a susceptible host with a contaminated object, surfaces (e.g. medical instrument, dressings, gloves that are not changed between patients and unwashed hands).
4. **Infection:** The presence of organisms and is causing illness.
5. **Health-care-associated infection (HAI):** Means a HAI infection defined by the National Healthcare Safety Network (NHSN) of the federal Centers for Disease Control and Prevention.
6. **Multidrug-Resistant Organisms (MDRO's):** Bacteria and other microorganisms that have developed resistance to antimicrobial drugs. Common examples of these organisms include:

MRSA	Methicillin/Oxacillin-resistant Staphylococcus Aureus. Can survive on surfaces up to 9-10 months
VRE	Vancomycin-resistant enterococci. . Can survive on surfaces up to 4 months
ESBL's	extended-spectrum beta-lactamases (which are resistant to cephalosporin's and monobactams)
CRE	Carbapenem-resistant Enterobacteriaceae (Resistant to all third generation cephalosporin's. Can survive on surfaces form weeks to months
C. Diff	Clostridium Difficile. Not resistant to drugs but is treated like a MDRO

DEFINED POPULATION:

At-risk populations:

a) Discharged from an acute care facility within the past 30 days.
b) Patients with a known history of MDRO.
c) Patients with chronic, poorly healing or non-healing wounds.
d) Dialysis patients.
e) Patients with long-term urinary catheters, or other long-term invasive devices.
f) Residents of long-term care facilities.
g) Immunosuppressed (e.g.; steroid use, cachexia)

POLICY:

1. Any patient with known MRSA colonization or history of MRSA infection shall be placed in contact isolation. A MRSA nasal swab will be collected; if the swab is negative the patient can be removed from isolation. If MRSA swab is positive the patient will remain in contact isolation until discharged or transferred from facility.
2. Any patient with known or history of VRE shall be placed in contact isolation until proven negative.
3. Any patient that has a known or suspected MDRO (e. g. MRSA, VRE, CRE) Infection will remain in contact isolation until discharged or transferred, or until the patient has had three successive negative screening cultures taken at least one week apart.
4. The Infection Preventionist or designee must approve the discontinuation of contact precautions with all patients that are confirmed C-diff positive during current admission and patients that have been transitioned to Swing Bed status. ***Repeat Clostridium difficile testing is not recommended if the patient's symptoms have resolved, as patients may remain colonized.*** If repeat testing is needed the test should be no sooner than 14 days after first positive and 3 days after completion or discontinuation of antibiotic therapy.
5. Active Surveillance Culturing (ASC): Each inpatient admitted to NIH shall be tested for Methicillin-resistant staph aureus (MRSA) within 24 hours of admission if meets one or more of the following criteria:
    a) The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection.
    b) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.
    c) The patient will be admitted to the intensive care unit.
    d) The patient is a resident of a long term care facility.
    e) Chronic, poorly healing or non-healing wound.
    f) Dialysis treatment.
    g) Long term indwelling devices (Foley, suprapubic catheter, Central Venous Catheter this includes PICC and Port a Cath, and dialysis catheter).
    h) Immunosuppressed (Steroid use, cachexia, chemotherapy, etc).
5. If patient that has a MDRO or colonization and is transferred or discharged to another facility the transfer paperwork must indicate that the patient has an active infection or is colonized. This

information will also be given verbally during hand off report and documented in patients chart when calling report to accepting facility.

6. Limit the movement and transport of the patient from the room for medically-necessary purposes only.
7. Laboratory personnel must notify the physician, or nursing staff of all positive MRDO cultures. Laboratory personnel must call and fax all positive MDRO results to facilities where patient has been transferred or discharged if the final results have not been reported and documented in patient chart prior to patient discharge or transfer form NIHD.
8. NIHD clinical staff will be educated about health-care associated infections ~~and licensed independent practitioners~~, MDRO, and prevention strategies at hire and annually.
9. Licensed Independent Practitioners will be educated about health-care associated infections, MDRO, and prevention strategies during onboarding and more frequently if indicated.

PROCEDURE:

1. Hand Hygiene performed per the World Health Organization.
2. Patients will be screened for indications requiring MRSA ASC during the admission assessment, and placed into the appropriate transmission-based isolation if the results of the screening under the above criteria are resulted as positive. Patients that have a history of MRSA will be placed in contact isolation, if MRSA nasal swab negative patient can be removed from contact isolation
3. If a patient tests positive for any MDRO, the **attending physician** shall inform the patient or the patient's representative immediately or as soon as practically possible per California Senate Bill No. 1058
4. Positive MDRO results are entered into the patient's reported problem list and a patient alert will be placed in the electronic health record. Physicians must document in patients chart current MDRO infection or colonization.
5. Appropriate isolation signage will be hung outside room visible to staff, family and visitors. A donning sign will be placed outside room and doffing sign placed inside room.
6. When nursing staff is notified by laboratory personnel with positive MDRO results, nursing personnel must notify the physician and document time, date and name of physician in the patient's medical chart soon as practically possible.
7. A patient who tests positive for *any* MDRO infection shall prior to discharge receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others. The education will be documented in the patients chart.
8. Any patient who has tested NEGATIVE and shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This does not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility.
9. Patient Movement and transport with MDRO's
    - Limit the movement and transport of the patient from the room for medically-necessary purposes only

- When transport or movement is necessary, ensure that infected or colonized areas of the patient's body are contained and covered.
- If patient is being transported by wheelchair, gurney or bed a clean sheet is placed over these items and the rails are wiped down using appropriate germicidal wipes according to type of organism patient is isolated for prior to exiting the room.
- Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting the patient.
- Don clean PPE to handle the patient at the transport destination.
- If there are two transporters required due to patient's conditions, one transporter should wear a clean cover gown and gloves to attend to the patient needs. The second transporter does not wear a gown or gloves and should open the doors, push elevator buttons, etc
- If patient is ambulating outside the room: The patient will perform hand hygiene and don a clean cover gown prior to exiting the room. The patient must be *clean, contained and cooperative*.

PROCEDURES TO REDUCE MDRO'S & HAI's

1. Hand Hygiene following the World Health Organization " Your Five Moments of Hand Hygiene"
2. Put on appropriate personal protective equipment (PPE) when entering an isolation room and per standard precautions.
3. Remove PPE and perform hand hygiene prior to leaving patients room.
4. Regular cleaning and disinfection of frequently touched surface areas (e.g., bedrails, call lights, telephones, doorknobs, bedrails and bedside table, etc.)
5. If patient is in isolation precautions use dedicated non- critical patient care equipment as much as possible. If unable to use dedicated equipment clean and disinfect per equipments manufactures instructions using hospital approved cleaner and disinfectant in between each patient use.
6. Clean and disinfect all non-critical patient care equipment in between each patient use following equipment manufactures instructions and hospital approved cleaner and disinfectant. This includes all movable medical equipment, point of care testing devices such as a glucometer, and transportable medical devices.
7. Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, office equipment, nursing stations and storage areas.
8. Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms and lounges.

REPORTING:

1. Infection Preventionist Manager, Employee Health/Infection Prevention Specialist or designee shall report to NHSN all positive MRSA, VRE blood cultures, and all positive C-difficile that are collected in the Emergency Department and Inpatient admissions. The data will also include number of inpatient days and number of Emergency Room visits monthly.

2. Infection Preventionist Manager, Employee Health/Infection Prevention Specialist or designee shall report quarterly to NHSN, Infection Control Committee and Nurse Executive Team:
    - All positive MRSA and VRE blood cultures, and all HAI C-diff infections.
    - All Central Line Bloodstream Infections and total inpatient central line days.
    - All catheter-associated UTI's that meets NHSN criteria and include inpatient indwelling catheter days.
    - All Ventilator Associated events that meets NHSN criteria and include inpatient ventilator days.
3. Infection Preventionist Manger, Employee Health/Infection Prevention Specialist or designee shall report quarterly to NHSN, Infection Control and Surgical Tissue Committees, and Nurse Executive Team all HAI Surgical Site Infections on all surgical procedures that NIH reports to NHSN.
4. Infection Preventionist Manager shall conduct yearly risk assessment and periodic assessment if indicated for MDRO acquisition and transmission. The risk assessment will be reported to the Infection Control Committee.

REFERENCES:

1. California Senate Bill No. 1058; http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_1051-1100/sb_1058_bill_20080831_enrolled.pdf
2. Centers for Disease Control and Prevention (2017). Management of Multidrug-Resistant Organism in Healthcare Setting, 2006. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/mdro-guidelines.pdf
3. Centers for Disease Control and Prevention. (2017). Multidrug-resistant organisms (MDRO) Management. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/mdro/index.html#va5
4. Centers for Disease Control and Prevention (2012). Frequently Asked Question about Clostridium difficile for Healthcare Providers. Retrieved from https://www.cdc.gov/hai/organisms/cdiff/cdiff_faqs_hcp.html
5. Centers for Disease Control and Prevention. (2017). **Facility Guidance for Control of** Carbapenem-resistant Enterobacteriaceae (CRE) - November 2015 Update CRE Toolkit. Retrieved from https://www.cdc.gov/hai/organisms/cre/cre-toolkit/index.html
6. Health Research & Educational Trust (HRET). (2017). Preventing MDRO Infections. Retrieved from http://www.hret-hiin.org/Resources/mdro/17/mdro_change_package.pdf
7. The Joint Commission. (2017). National Patient Safety Goals 07.03.01 Implement evidenced-based practices to prevent health-care associated infections due to multidrug-resistant organisms in critical access hospitals.
8. The Joint Commission. (2017). Infection Prevention and Control IC. 02.01.01 & IC.02.02.01. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

CROSS REFERENCE P&P:

1. Infection Control Plan
2. Disinfection, noncritical patient care equipment, ambulatory care. Lippincott Procedures

3. Environmental Disinfectant-Cleaning Solution
4. Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge
5. Contact Precautions Lippincott Procedures
6. Personal Protective Equipment (PPE) Putting on Lippincott Procedures
7. Personal Protective Equipment (PPE) Removal Lippincott Procedures
8. Hand Hygiene Lippincott Procedures
9. MRSA Identification by Cepheid PCR

Approval	**Date**
CCOC	
Infection Control Committee	02/27/18
MEC	03/06/18
Board of Directors	
Last Board of Directors Review	05/17/17

Developed: 4/2010bss;
Reviewed: 5/11bs; 9/12 BS; 11/15 NH,
Revised: 11/17rc
Supersedes:
Index Listings: MRSA, Contact Precautions, MDRO

PURPOSE:

To verify which N95 Disposable Mask that an employee can wear, via quantitative fit testing. Respirators do not eliminate the risk of contracting disease or infection. They are intended to be used in conjunction with other infection control measures such as patient identification, isolation, negative pressure ventilation, and health care worker screening.

The test shall not be conducted if there is stubble beard growth, beard, mustache, or sideburns that cross the respirator-sealing surface.

If an employee does have a beard, mustache or sideburns that prevent them from being fit tested, and they refuse to shave, that department will need to order a Powered Air-Purifying Respirator (PAPR) and the department / employee will be responsible for storage, inspecting, cleaning, fit testing and repairing.

All PAPR respirators shall be inspected in accordance with the manufacturer's recommendations, and shall be checked for proper function before and after each use.

PRECAUTIONS:

Fit Testing People Who Smoke Cigarettes or Cigars

Smokers exhale particles for at least 30 minutes after they have smoked a cigarette or cigar. The PortaCount tester can count these particles and will interpret them as if they were caused by face seal leakage. It is very important to instruct individuals to not smoke for at least 30 minutes prior to fit testing.

Isopropyl alcohol is hazardous material.

Do not ingest or allow to contact your eyes or skin. Refer to the Material Safety Data Sheet (MSDS). Always recap alcohol fill capsule and other containers immediately to prevent absorption of moisture and the escape of alcohol vapors.

Because the Alcohol Cartridge is inserted into the Cartridge Cavity of the instrument, it is critically important to keep it clean. Do not allow the black part of the Alcohol Cartridge to make contact with any surface that may be dirty.

POLICY:

Fit testing should be conducted during orientation and per CalOSHA's guidelines. In addition, fit testing should be repeated when a worker develops any condition that may affect a change in the way their respirator fits the face such as:

- Ten percent or greater change in weight
- Dental conditions.
- Reconstructive or cosmetic facial surgery.
- Facial scarring in respirator sealing area.

Fit testing should be repeated when any of these conditions occur to ensure that the respirator continues to demonstrate a satisfactory face seal.

All employees need to complete an initial "Respirator Medical Evaluation Questionnaire" that needs to be reviewed by a physician or other licensed health care professional before the actual fit testing. Once completed return questionnaire in a confidential envelope addressed to the Employee Health Nurse. ---

Employees need to watch the DVD videos "**Putting on PPE and Taking off PPE**" before the testing. This DVD can be found on the hospital intranet under Education then Infection Prevention.

PROCEDURE:

STEP 1 ---Prepare the PortaCount for Fit Testing

1. Make sure the PortaCount tester is turned off.

2. Remove the Storage Cap from the PortaCount tester by twisting it counter-clockwise.

3. Open the Alcohol Fill Capsule by twisting the Storage Cap off (counter-clockwise).

4. Remove the Alcohol Cartridge from the capsule and gently shake it to allow excess alcohol to drip back into the Alcohol Fill Capsule.

5. Insert the Alcohol Cartridge into the Cartridge Cavity of the PortaCount tester. It should slide in with little effort. DO NOT FORCE IT. As you approach full insertion, firmly twist the Alcohol Cartridge clockwise until it locks into position.
6. Recap the Alcohol fill Capsule with the storage cap.

If the Alcohol Fill Capsule has no alcohol or the alcohol level is below the fill line:

7. Open a bottle of alcohol. Invert the bottle and insert the nozzle end into the Alcohol Fill Capsule as far as possible to make certain you do not inadvertently spray alcohol anywhere except into the Capsule.

8. Squeeze the alcohol into the Alcohol Fill Capsule until it is even with or slightly above the fill-line.

9. Recap the alcohol bottle immediately.

10. Place the Alcohol Cartridge back into the Alcohol Fill Capsule and wait at least 2 minutes while the alcohol wick inside the Alcohol Cartridge soaks up the alcohol.

11. Make certain the alcohol cartridge is clean. If it has been contaminated, refer to the Service and Maintenance chapter and follow the instructions to replace it. If it is clean, insert the Alcohol Cartridge into the Alcohol Fill Capsule and turn capsule clock-wise until it locks in place.

STEP 2 ---Run Daily Checks

1. Connect the USB cable from the PortaCount to the Lap Top Computer.

2. Power up computer and sign in with your NIH login and password

3. Power up the PortaCount. The PortaCount fit tester goes through a warm-up period before it is ready to use.

4. On the computer screen, select the **Fit Pro icon**.

5. With the mouse select **Daily Check**; it is the icon with the green check mark. Make sure to select the "**Use N95**" box before you go any farther.

6. Remove the HEPA filter or mask and press **Start**. The first check is the Particle Check, which determines if the concentration of particles in the ambient air is sufficient to conduct fit testing. **If the test fails** you will need to use the room humidifier with tap water to create a particle concentration.

7. The next check is the Zero Check, which provides assurance that there are no leaks in the system. **Attach the HEPA filter to the Clear Sample Tube, wait for 20 – 30 seconds and then** press start. If the Zero Check fails check the connection to the HEPA filter, it should be tight.

STEP 3---Conducting Fit Tests

1. On the Activities tab, press **Start a Fit Test**; a green circle icon with an arrow in the center, the **People List** dialog appears.

2. Select the person to fit test as follows:

   - If the person shown on the dialog is the one you want to fit test, press **Next** to select the respirator for the fit test. Press **Next** to continue.

   - If the person shown on the dialog is not the one you want to fit test, click the arrow on the **People List** field to display the names in the People Table, click on the name of the person you want, verify the correct name is displayed, then, press **Next** to select the respirator for the fit test.

   Note: If the person you want to fit test is not in the database, press **New** and create a new record by typing in the information required. When you are done, press **Next** and confirm that you want to save the new entry and use it for this fit test.

3. After you press **Next**, the Respirator List dialog appears.

   - If the respirator you want to use is displayed, click **Next**.

   - If you want to select a different respirator, click the drop down box on the **Respirator List** field to display a list of all the respirators in the database. Select the respirator you want to use, click **Next** to select the current protocol.

4. After you press **Next**, the **Current Protocol** dialog box appears, the mask size and operator fields are blank. You must fill in these fields before you can continue. **Regular, small or OSFA** (one size fits all).

5. The N95 mask needs to have a sampling probe inserted, see PortaCount Manual.

6. Instruct the person being tested to put on the respirator before the fit test starts to purge the particles trapped inside the respirator. Have the subject don the mask without assistance. Fit test results depend on the subject knowing how to properly don the mask. All employees should watch the DVD "**Donning and Doffing PPE**" before the testing. Do not allow the subject to adjust the mask during exercises. Have the fit test subject hang the tubing support neck strap around his or her neck, adjusting it to a comfortable position. The tubing support neck strap should be positioned so that the tubing does not pull on the mask.

7. **Press Start**. Fit testing begins immediately, and the first exercise name appears. The elapsed exercise time also appears as a graphic progress bar. The PortaCount Pro fit tester, beeps to alert the person being tested it is time to begin the next exercise.

Have the test subject follow the exercises one after another when prompted by the instrument, each exercise takes approximately 60 seconds to complete.

Test Subject Should Be Standing While Doing These Exercises.

Exercise Name	Description
Normal breathing	In a normal standing position, without talking, the subject shall breathe normally.
Deep breathing	In a normal standing position, the subject whall breathe slowly and deeply, taking caution so as not to hyperventilate.
Turning Head side to side	Standing in place, the subject shall slowly turn his/her head from side to side between the extreme positions on each side. The head shall be held at each extreme momentarily so the subject can inhale at each side.
Moving Head up and down	Standing in place, the subject shall slowly move his/her heard up and down. The subject shall be instructed to inhale in the up position (i.e., when looking toward the ceiling).
Talking	The subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor. The subject can read from a prepared text such as the Rainbow Passage, count backward from 100, or recite a memorized poem or song.
Grimace	Grimace by smiling and/or frowning to create a leak in the respirator face seal. . When performing the grimace, you are intentionally creating a break in the face seal in order to see if the mask re-seals itself afterwards. Achieving a passing fit factor on the next exercise proves successful re-sealing.
Bending over	The subject shall bend at the waist as if he/she were to touch his/her toes.
Normal breathing	In a normal standing position, without talking, the subject shall breathe normally.

8. If the test was a Pass, the fit test is over. Press View Record, then Print Report and select printer.

9. If a test subject exhibits difficulty in breathing during the tests, he or she shall be referred to a physician (trained in respiratory disease or pulmonary medicine) to

determine whether the test subject can wear a respirator while performing his or her duties.

10. If the fit test failed, determine the reason and repeat the test. Some common reasons for failure are described below. The PortaCount measures the overall fit factor; therefore you could fail two or three tests but overall pass the fit test.
    - Alcohol cartridge is not tightly inserted or an O-rig is missing. Make sure the alcohol cartridge is installed properly and all O-rings are in position.
    - Starting fit test too soon after mask is donned.
    - Leaking respirator probe or fit test adapter.
    - PortaCount fit tester sample tube leaks where attached to probe or adapter due to wear. Cut a short piece off the end of the tube to expose a fresh end.
    - Hair interfering with face seal.
    - Cigarette smoker.

11. When finished with testing remove the Alcohol Cartridge from the Cartridge Cavity of the PortaCount tester. Place back into the Alcohol Fill Capsule, and place the cap back onto the PortaCount.
12. Yearly fit testing is mandatory for all staff entering an Airborne isolation Precaution room or an Airborne Infection Isolation room.

Reference: CAL/OSHA ATD Standards; PortaCount Pro operations manual

Committee Approval	**Date**
Clinical Consistency Oversight Committee	1/29/18
Respiratory Care	
Infection Control Committee	2/27/18
Medical Executive Committee	3/6/18
Board of Directors	
Last Board of Directors Review	

Revised 2-2017kc/
Reviewed
Supercedes

PURPOSE:
To identify the process for opening and closing a nursing department within the NIHD hospital facility

POLICY:

1. The scope of service defines the routine hours of department operations.
2. The department manager and/or house supervisor will be responsible for opening and/or closing a department outside of the department's routine operations.
3. Nursing departments may be opened or closed due to volume surges and/or construction needs.
4. If a department is closed based on construction, the Infection Control Preventionist must inspect and approve department re-opening prior to any placement of patients.
5. The ICU will generally be open with the presence of a monitor tech for telemetry oversight 24/7; exceptions include situations where the ED has been informed they are responsible for watching their own monitors and there is no telemetry or continuous oximetry patients requiring central monitoring.
6. Perinatal Unit will always be open with an RN in the unit for potential precipitous delivery, 24/7.
7. The House Supervisor will be responsible for coordinating staffing according to the Staffing Management Plan when it becomes necessary to close a department.
8. Pharmacy will be notified of department closure for oversight of Omnicell.
9. Environmental Services may be asked to do a deep cleaning during department closure.
10. Departments that are closed outside of routine operations such as Surgery and PACU are locked.
11. Any Medical Record in a nursing unit that is closed will either be returned to Medical Records or secured in a locked cabinet.

CROSS REFERENCE P&P's:

1. Information Security and Data Integrity
2. Scope of Service Perinatal

Approval	**Date**
Clinical Consistency Oversight Committee	
Infection Control Committee	2/27/18
Medical Executive Committee	3/6/18
Board of Directors	
Last Board of Director review	3/15/17

Developed: 5/13
Revised:
Reviewed:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date:

POLICY STATEMENT:

1. Intensive Care Unit (ICU) nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient needs, capabilities, and limitations; nursing diagnosis; planning; interventions; and evaluation of patient response.
2. The patient age-specific population served is:
   a. Adult: 18 years of age to 65 years of age
   b. Geriatric: > 65 years of age

PROCEDURE:

The ICU patient and/or family-caregiver can expect:

1. **ON ADMISSION OR TRANSFER INTO THE DEPARTMENT:**
   A. To be greeted immediately upon arrival to the unit including:
      a. Introduction of nursing and ancillary staff
      b. Explanation of what to expect within the next hour
      c. A clean patient room with appropriate supplies and equipment
      d. Assessment of level of assistance required to complete activities of daily living, including transferring, ambulation, self-care, and feeding; support provided to meet identified need.
      e. Orientation to room including, but not limited to the operation of:
         i. Call light use
         ii. Bed controls
         iii. TV and light controls
         iv. Phone
         v. Bathroom location and toileting options
         vi. Safety procedures
         vii. Equipment in use
         viii. Department routine
      f. Pain, potty, and positioning addressed
      g. Additional comfort needs including but not limited to:
         i. Fluids
         ii. Food and nutrition
         iii. Blankets
         iv. IV site
         v. Traction
         vi. Safety devices
         vii. Environmental assessment to ensure items such as Kleenex and trash bag are within reach
         viii. Personal hygiene supplies provided, including hand sanitizer, soap, lotion, toothbrush, toothpaste; other supplies such as razor, shaving cream, denture care available on request
         ix. Patient personal equipment checked prior to usage
   B. To receive information about the patient/family's Speak Up Program, Patient Rights, Patient Safety, Patient Advocate, Advance Directives, Infection Control, and Rapid Response.
   C. To have an RN assess his/her admitting or transfer condition (quick check) within 30 minutes of arrival.
   D. To have an RN initiate a nursing assessment within 4 hours of admission, to be completed within 12 hours, including:
      a. Physical and social assessment.

b. Patient profile, to include home medications, pre-arrival medications, reported problems and procedures, implants, allergies, immunizations, family history, education, occupation, use of alcohol, tobacco, and other drugs, patient education provided
c. Interdisciplinary referral based on functional screens within the nursing assessment.
d. Nursing plan of care individualized for patient.
e. The nursing care of patients will be supervised by nurses adept in skills and knowledge of a critical care patient. The priority of data collection activities is driven by the patient's immediate condition and/or anticipated needs.

E. To have an RN review and initiate physician admitting orders within 4 hours of admission, including review of medical staff plan of care as written
F. To have an RN initiate discharge planning at time of admission, to be readdressed throughout stay, including:
   a. Patient goals for hospitalization
   b. Referral to interdisciplinary team, including but not limited to: dietary, social services, physical therapy, speech therapy, and pharmacy.
G. To have pharmacy review the medication list for appropriateness within 24 hours of admission/transfer.
H. The ICU/CCU RN's practice is guided by the ANA's Code for Nurses, AACN's Ethic of Care, and ethical principles.
I. The AHA ACLS protocol will be instituted when necessary for all ICU patients, older than 13 years of age.

2. **THROUGHOUT THE STAY:**
   A. To be treated in accordance with NIH's policy entitled "Patients' Rights"
   B. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
   C. To have care delivered based on standards of practice for the diagnosis identified.
   D. To have a Physician oversee care with site visit every 24 hours.
   E. To have Medical Staff consultations completed within 24 hours of referral.
   F. To have an RN monitor and assess the patient's health status at the beginning of each shift and as the patient's condition warrants.
   G. All patients will have continuous cardiac monitoring in the most appropriate leads. Monitor strips will be placed on the chart at the beginning of each 12-hour shift and PRN. A 6-lead printout will be documented every 12 hours. Changes in rate, rhythm, or morphology will be documented PRN. Monitoring leads, PR, QRS, and QT interval measurements will be noted.
   Interpretation of the cardiac rhythm will be documented on the strip by the RN or the ICU technician at the beginning of each shift and PRN changes or dysrhythmias.
   H. Monitor alarms will be will be set and reviewed at the beginning of each shift and changed, as needed based on patient condition. Changes in the alarms will be made **only** by the nurse in charge of the patient or in consultation with that nurse.
   I. All patients will be on intake and output monitoring. I&O's will be recorded every 2 hours.
   J. All patients will be weighed daily. Bed scale weights will ideally be done on the evening shift around 10 PM to correlate more accurately to the 24 hour I&O.

K. All patients will have a complete assessment completed every shift and as the condition dictates. Vital signs including Blood Pressure, Pulse, Respiratory rate and O2 saturation will be completed a minimum of every 2 hours and as the condition dictates. A temperature will be obtained every 8 hours or as the condition dictates. All completed assessments will be documented in the EHR in a timely manner.

L. All patients will have an IV of NS at a 'to keep open rate' for the first 8 hours unless otherwise ordered by the physician. After that, the IV may be saline locked according to P&P, if the patient remains stable.

M. An intravenous infusion pump will be used on all patients receiving intravenous fluids or drugs..

N. All patients will have suctioning performed whenever indicated. This includes oral/naso pharyngeal and endotracheal suctioning.

O. The Ventilator Associated Pneumonia (VAP) policy will be followed as indicated.

P. In the event that the patient's respiratory status deteriorates, the nurse may order arterial blood gases and /or Chest x-ray and notify physician.

Q. Blood may be withdrawn by the ICU R.N. from the central or arterial line for laboratory analysis. Respiratory Therapists may withdraw blood from the arterial line for ABGs according to P&P.

R. Blood drawn from arterial lines prior to lab withdrawal will be discarded, not re-infused. Exceptions to this will be: if specifically ordered by attending physician or if there is a venous arterial blood management protection (VAMP) system attached to the arterial or central line. This is a closed system allowing for reinfusion.

S. In the event of inability to access an IV line in the upper extremities, IV venipuncture may be performed in the lower extremities after notifying the attending Physician. The Physician must be notified of difficult IV access so He or She can arrange for insertion of a central line.

T. Monitoring electrodes will be checked each day and replaced as necessary.
The skin will be prepped with alcohol to remove excess skin oils. Excess hair may be clipped/shaved for good contact.

U. Care of the adult ICU/CCU patient will be guided by the policies and procedures at Northern Inyo Hospital.

V. A FSBS may be performed by the RN or LVN if the patient is demonstrating signs or symptoms suspicious for hypo/hyperglycemia. The physician will be informed of all abnormal results.

W. In the event of medication incompatibility, an IV at TKO rate or saline lock may be inserted.

X. Nursing staff will be responsible for knowledge of medication given and utilizing appropriate resources to gain that knowledge.

Y. All patients receiving vasoactive and antidysrhythmic agents will have their BP, heart rate and appropriate EKG intervals measured prior to administration; notify physician of significant changes and have parameters for drug administration.

Z. All sedation/analgesia will be given according to the IV sedation analgesia guidelines.

AA. The ICU R.N. may discontinue arterial lines and central lines and remove the sutures that retain them if they become dislodged, site infiltration or if ordered by the physician. The physician will be notified as soon as possible if the line is discontinued without a doctor order.

BB. The nurse may obtain a 12-lead EKG and will call the physician in the event of:
   a. Chest pain unrelieved by ordered medications such as Nitroglycerine or Morphine Sulfate.
   b. New onset of chest pain.
   c. Significant changes in the cardiac rhythm.

CC. To have the physician updated and informed of response to care and/or significant changes as demonstrated by:

a. Abnormal or worsening critical signs specific to patient's baseline
b. Abnormal or worsening lab values
c. Significant change in Level of Consciousness (LOC)
d. Significant or worsening change in physical assessment
e. Significant change or imbalance in Input and Output (I&O)
f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment
g. Inability to control pain or obtain pain relief
h. Any untoward occurrence/event occurring in the hospital
i. Significant change in cardiac rhythm

DD. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response Team initiation

EE. To have pain assessed and managed in a systematic way to achieve optimal relief.

FF. To have hourly rounding from 0800 to 2400 and every 2 hour rounding from 2400 to 0800 to address:
a. Pain, potty, positioning.
b. Comfort needs.
c. Environment assessment, to include maintenance of quiet, therapeutic atmosphere.

GG. To have safety measures identified specific to each patient including:
a. Patient identification band in place; staff to use at least two patient identifiers for medications and procedures.
b. 5 rights of medication administration practiced.
c. Time out as appropriate for identified invasive procedures.
d. Fall risk assessment completed at the beginning of every shift and with change of condition.
i. Interventions in place specific to the patient
ii. High risk patient to be awoken at agreed-upon time for toileting
e. Skin assessment at the beginning of every shift
i. Interventions in place specific to patient to prevent new breakdown, and to treat existing skin breakdown
f. Restraint-free environment emphasizing alternatives to restraint:
i. Comfort measures
ii. Patient orientation techniques
iii. Patient safety alert devices
iv. Patient location
v. Safety attendant in room
g. Restraints only used if less restrictive measures not successful and the patient is at risk for injury of self. Smoke-free environment
h. Assessment for suicidal risk

HH. To have preventative measures followed to avoid patient infections, pneumonia, and blood clots.

II. To be educated throughout the admission to support understanding of:
a. Health status, current diagnosis, and plan of care.
b. Self-care needed to maintain and improve health status.
c. Basic health and safety practices, including opportunity to communicate concerns about safety issues before, during, and after care is received.
d. Oral health.
e. Nutrition interventions.
f. Habitation or rehabilitation techniques to help patient reach maximum independence.

g. Equipment usage during stay and equipment needs for discharge.
h. Fall reduction strategies.
i. Pain, risk for pain, and methods of pain management.
j. Medication name, dosage, route, timing, and reason for receiving

JJ. To have continuity of care maintained between caregivers and departments through appropriate sharing of information (SBAR-QC).

KK. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.

LL. To have nutritional needs assessed, and nutrition provided that meets the patient's special diet, including cultural, religious, or ethnic preferences. To have services that support family time, social work, nursing care, dental care, rehabilitation, and discharge needs.

MM. To have palliative and terminal care as required The ICU/ CCU RN and physician address the wishes of patients related to end-of-life decisions.

NN. Patients have the right to refuse care, treatment and services in accordance with the law and regulation

OO. All admitted patients will be entered in the ICU logbook.

3. **ON TRANSFER WITHIN NIH:**
   A. To have discharge transfer assessment completed by transferring RN.
   B. To have patient assessment completed by receiving RN.
   C. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
   D. To have patient/family updated on reason for transfer, location moved, and change in plan of care.
   E. To be transferred with all belongings.
   F. To have medications/orders reconciled upon transfer by receiving RN/Pharmacy.

4. **ON DISCHARGE/TRANSFER TO ANOTHER FACILITY:**
   A. To have discharge transfer orders reviewed with patient/family.
   B. To have discharge transfer assessment completed by RN and report called to receiving facility RN.
   C. To have transportation arranged including:
      a. Medical condition.
      b. Orders for care level during transport.
      c. IV/Medication maintenance as appropriate.
      d. Record of care transported with patient.
   D. To have discharging transfer RN give report to transport team, MD/RN/Paramedic/EMT as appropriate.
   E. To be transferred with all personal belongings and medications.

5. **ON DISCHARGE:**
   A. To have discharge assessment completed by RN.
   B. To have written discharge instructions provided to patient/family member by RN, including clarification of:
      a. Who to call for questions.
      b. Nature of medical condition and what symptoms to report to MD.
      c. Medications to take, list of medications already given that day, new prescriptions.
      d. Follow-up appointment, including outpatient diagnostic test and lab work orders.

e. Medical equipment needed at home, including vendor to call for assistance.
f. Home Health/Hospice/Meals on Wheels contact information as ordered.
g. Activity level and return to work.
h. Dietary restrictions.

C. To be discharged with all belongings and medications.
D. To receive hospital follow-up call.

6. **ON EXPIRATION:**
   A. To have Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of impending death.
   B. To have all Medical Staff assigned to the case, Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of death.
   C. To have all belongings returned to family or sent with body to Funeral Home.
   D. To have post-mortem care completed and body released to Funeral Home or Medical Examiner.

REFERENCE(S):

1. General Acute Care Hospitals. (2016). 22 CCR §§ 70211-70217
2. American Nurses Association. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org
3. JCAHO NC3.1.2 1992

CROSS REFERENCE HOSPITAL P&P:

1. A Quick Check
2. Definition of Nursing Practice
3. Hand Off; Standardized Nursing Communications Policy
4. Obtaining Consent for Organ and Tissue Donation
5. Patients' Rights
6. Patient Transfer/Discharge to Another Facility

Approval	**Date**
Clinical Consistency Oversight Committee (CCOC)	6/19/17
Med Services/ICU	7/27/17
Medical Executive Committee (MEC)	3/6/18
Board of Directors	
Last Board of Director review	

Developed: 3/96
Reviewed:
Revised: 01/01, 02/2004, 11/07 jk, 02/09rs, 04/09 FM, 9/12jk 6/17la, 2/18ta
Last Board of Director review: 4/19/17
Index Listings: Standards of Care, ICU; ICU Standards of Care; Patient Care, Standards in ICU

NORTHERN INYO HEALTHCARE DISTRICT
Warfarin Protocol – Inpatient Adult
POLICY AND PROCEDURE

Title: Warfarin Protocol – Inpatient Adult	
Scope: Hospital Wide	Manual: Pharmacy
Source: Interim Pharmacy Director	Effective Date: 2/15/18

PURPOSE: This procedure outlines the Pharmacy Department's responsibilities when warfarin is ordered per protocol in adult inpatients.

PROCEDURE:

	Description	Notes
1.	• Adult inpatients with a physician order for "Warfarin Dosing Per Pharmacy Protocol/Warfarin (Coumadin) Pharmacy Dosing Order" will be dose and monitored per this protocol. • All adult inpatients NOT on "Warfarin Dosing per Pharmacy Protocol" will be reviewed daily. Refer to Step 16.	*New orders received after 23:59 will not start warfarin until the following day
2.	Each morning, obtain a current list of all inpatients on the Warfarin Protocol. Use the following resources to ensure that patients are not missed: A. The Northern Inyo Hospital Reports "Warfarin Per Pharmacy Protcol" automatically prints each morning and includes all patients with active "Warfarin Per Pharmacy Protocol" orders. Compare the current list with the previous day's list to identify any new patients and to ensure that every patient from the previous day has been accounted for. B. Check for any possible warfarin protocol related orders forwarded from the evening and night pharmacists.	
3.	For all new patients: A. Complete a warfarin monitoring form after reviewing the patient chart and all available patient data. B. If a baseline PT/INR has not been completed, enter an order for a NOW PT/INR before dosing warfarin	A baseline PT/INR on record in a patient's chart from an out-patient lab visit is acceptable if within 30 days for planned in-patient procedures (e.g. orthopedic surgery). For inpatients-baseline PT/INR within the last 24 hours is required. If patient is a re-admit, create a new patient profile. You may refer to the old profile, but do not use it for the current admission record. **If patient is on apixaban, dabigatran, or rivaroxaban as well as any new orders for apixaban, dabigatran or rivaroxaban, see Step 14
4.	For all patients continuing from the previous day, update the warfarin monitoring form daily.	Review medication profile daily. Update the profile if the interacting medication started or stopped.
5.	"The Warfarin Monitoring Report" from Northern Inyo Hospital will automatically print to designated printers. This report is used to obtain the current PT/INRs results for all in-patients on warfarin	

6.	Warfarin Dosages will be determined after reviewing all pertinent labs and patient parameters. Screen patients for drug-drug, drug-food, and drug-disease interactions prior to dosing daily. Doses will be determined based on ACCP Guidelines/clinical judgment	See attached Guidelines for Dosing Warfarin (Addendum B). If on argatroban see Addendum D. For patients with Ventricular Assist Device (VAD), see Addendum F
7.	Dosages will be titrated to achieve the targeted INR determined by one of the following: • As indicated in the physician order or physician progress note. • Per physician desired range (physicians may designate their preference via a signed letter to Pharmacy. A copy of this letter will be maintained in the pharmacy.) • If not specified, an INR of 2-3 will be targeted. • For patients with a Ventricular Assist Device (VAD), see step 15	If a patient has a concomitant disease state that requires a target INR higher than stated by the physician's desired range, contact the physician to discuss the current consensus recommendations for warfarin anticoagulation (ACCP Guidelines) and obtain a new order. If patient is not therapeutic within 5 to 7 days of initiation, contact the physician to add bridge therapy (if not already on) or to change to alternative anticoagulant
8.	Scheduling of anticoagulation lab monitoring (PT/INR) will be determined according to the following suggested schedule. For all in-patients: a daily PT/INR will be ordered for the duration of the warfarin protocol For Swing Bed Patients, pharmacists may, but are not required to, follow the following monitoring guideline: <u>Stage of Anticoagulation</u> — <u>Next PT/INR</u> Initial Dosing — 1-3 days Dose increase/decrease — 2-4 days Confirm the maintenance dose — 4-7 days Routine Follow-Up (Stable pts.) — 7-14 days	If a lab is missed for any reason, the pharmacist will re-schedule the lab test as soon as possible.
9.	The pharmacist will enter an order for warfarin and the next PT/INR for each patient on the warfarin protocol.	Routine orders for daily INR's is used when patients are first placed on the protocol
10.	Document current PT/INR, warfarin dosage ordered, next PT/INR ordered, and any pertinent information/rationale in the Progress Note Section of the electronic health record and in the warfarin monitoring form.	Examples of pertinent information include drug-drug interactions, or if on overlap therapy.
11.	Notify the physician of any adverse effects to determine follow-up and treatment.	Notification may be done by nurse or pharmacist. If INR is supratherapeutic, see dosing recommendations for Vitamin
12.	Follow warfarin protocol patients for the duration of their inpatient stay or per specific physician orders.	
13.	For Orthopedic Patients ONLY: Upon discharge home, IF there are orders to continue warfarin as outpatient, the pharmacist will: • Determine the warfarin maintenance dose (acting as an agent of the referring physician). Enter outpatient warfarin prescription in the electronic health record. Strength, quantity and directions to be called in by the RN to a pharmacy designated by the patient.	Handouts to be given to the patient: 1. Coumadin (warfarin) discharge instructions 2. Vitamin K content in food 3. Dosage calendar

	• Determine the date of the next PT/INR (acting as an agent of the referring physician) to be drawn by home health or at an outpatient lab. • Counsel the patient on anticoagulation therapy (verbal and written). Document activities in the electronic health record (See Addendum E) • Document education of patient in the electronic health record	
14.	**If patient is on dabigatran or rivaroxaban – • Contact Physician to discontinue apixaban, dabigatran, or rivaroxaban. • If Physician insists on continuing, monitor aPTT and INR (No more than 3 days on both apixaban, dabigatran, or rivaroxaban and warfarin) • If aPTT is 2 to 2.5 times baseline prolonged or INR > 3, contact the Physician to discontinue apixaban, dabigatran, or rivaroxaban.	Document in electronic health record intervention.
15.	For patients with Ventricular Assist Device (VAD) • Use warfarin monitoring form for patients with VAD (addendum G) • If not specified initial INR goals will be 1.8-2.5 for HeartMate device and 2 to 3 for HeartWare device	See VAD warfarin dosing guidelines for initiating warfarin (addendum F)
16.	For adult inpatients NOT on "Warfarin Dosing per Pharmacy Protocol": • Ensure appropriate PT/INR is done. If clinically warranted, the anticoagulation pharmacist may automatically enter an order for a PT/INR • The pharmacist will contact the physician if any warfarin changes are needed	All patients who received warfarin will be listed on the Warfarin Monitoring Report
17.	For patients newly diagnosed with VTE (PE/DVT): • If patient meets criteria for VTE Core Measure 3 while in the hospital, the pharmacist may discontinue the parenteral anticoagulant the patient is on and discontinue the order for case management to arrange for home enoxaparin.	VTE Core Measure 3 – Venous Thromboembolism Patients with anticoagulation overlap therapy • Overlap therapy should be administered for at least 5 days with an INR greater than or equal to 2 prior to discontinuation of the parenteral

References:

1. National Patient Safety Goals 03.05.01
2. High Alert Medications: Preparation, Dispensing, Storage* NIHD Policy

Approval	**Date**
P&T Approval	2/15/18
MEC Approval	3/6/18
Board of Directors Approval	
Last Board of Directors Review	

Developed: Nicholas Vu (2/6/18)
Reviewed: 2/15/18
Revised:
Supersedes:
Index Listings:

Addendum A

Northern Inyo Hospital 150 Pioneer Lane Bishop, CA 93514	**Room**			Patient name/account # (sticker here)

Ordering MD: _____ Diagnosis: _____Target INR: _____

HT WT SCr ALB BILI LFT PLTS	**Interacting Drugs** (circle/highlight if on)		
	Increase INR (major): Amiodarone Fluconazole Voriconazole Metronidazole Marcolides Quinolone TMP/SMX Propafenone *Increase INR (others):* Allopurinol Aminoglycoside SSRIs Corticosteroids Fibric acid Lovastatin NSAIDs Phenytoin Thyroid Fluvstatin Omeprazole/Esomeprazole	*Increase bleeding risk:* ASA NSAIDs Corticosteroids Clopidogrel Prasugrel Ticlodipine Vitamin E (high dose) *Apixaban *Dabigatran *Rivaroxaban	*Decrease INR:* Antithyroid Barbiturates Carbamazepine Nafcillin Rifampin Vitamin K Cholestyramine Phenytoin MVI
Allergies:			
Disease Factors:			
Home Meds:			
Prior Home Warfarin Dose:			

SEE OLD PROFILE? Y/N **On bridge therapy?** (circle drug) Enoxaparin Heparin Argatroban
(ensure overlap of at least 5 days for VTE core measure)

	PRE	OP	1	2	3	4	5	6	7	8	9	10	11	12	13	14
DATE																
TIME																
HCT																
PT																
INR																
DOSE (MG)																
RPH initials																
Other info																

	15	16	17	18	19	20	21	22	23	24	25	26	27	28	F/U

Addendum B

Guidelines to assist in Pharmacists Dosing Warfarin

(consider nutritional status, disease states, and drug interactions)

If a request for "Warfarin per Rx Protocol" is received:

1. Has this patient been taking warfarin in the past, either as an inpatient or outpatient? (Check EHR for current orders, check H&P, outpatient medications, or check with patient if regimen is not listed).
2. Is there a recent INR/baseline INR? (Check EHR for labs). Do not dose warfarin without a recent INR. The dosing protocol allow ordering a STAT INR.
3. **If the patient has a therapeutic INR,** determine what the patient was on at home and continue this dose and order a daily INR.
4. **If the patient has a supratherapeutic INR**, hold dose for today and order a daily INR.
5. **If the patient's INR is subtherapeutic**, compliance is often an issue. If it is close to baseline (=<1.1), initiate dosing per guidelines to assist in pharmacist dosing warfarin. If the INR is slightly below therapeutic, continue the patient's home dose and order a daily INR.

NEW WARFARIN PATIENT DOSING GUIDELINES

1. Obtain the patient's age, weight, and height, etc.
2. Obtain the following labs:
    a. SCr: patients with renal dysfunction may be more sensitive.
    b. LFTs: elevated liver function tests may indicate some coagulopathy
    c. ALB: low albumin is usually an indication of smaller dose requirements.
    d. PLT: low platelets may indicate that ADR's are more likely on AC.
3. Take note of medications that may interact with warfarin and of patient's nutritional status.
4. Patients in ICU for sepsis, hemodynamic instability, etc. should be dosed conservatively at the beginning.
5. Order a daily INR for all new start on Warfarin per Rx protocol.

**If available – Genetic polymorphism of CYP-450 2C9 VKORC1 will affect patient's response to warfarin – see other references (e.g. Clinical Pharmacology, Lexicomp) for dosing guidelines

Addendum B (Northern Inyo Hospital)
Guidelines to assist in Pharmacists Dosing Warfarin
(consider nutritional status, disease states, and drug interactions)

Initial Dosing: Based on sensitivity for target INR 2 to 3

	INR	**High Sensitivity**: • Baseline INR > 1.5 • >65 years of age • Significant hepatic disease • Severe renal impairment • Decompensated CHF • Malnourished • Malabsorption syndrome/chronic diarrhea • Hypoalbuminemia (esp<2) • Cancer • Thyrotoxicosis • Weight <= 50 kg	**Moderate Sensitivity:** • Baseline INR 1.2-1.5 • 50-65 years of age • Concurrent CYP-450 hepatic enzyme inhibitor • Asian Race	**Low Sensitivity** • Baseline INR <1.2 • <50 years of age and NO other risk factors
Day 1	Baseline INR	5 mg (2.5 mg if multiple high sensitivity factors)	7.5 mg (5 mg if multiple moderate sensitivity factors)	10 mg
Day 2	Δ INR = 0 to 0.2 Δ INR = 0.3 to 0.5 Δ INR > 0.5	Repeat Initial dose Decrease initial dose by 25 to 50 % Decrease initial dose by 75% or hold dose		
Day 3	**INR < 1.5** Δ INR = 0 to 0.2 Δ INR > 0.2 **INR 1.5 to 1.9** Δ INR = 0 to 0.2 Δ INR > 0.2 **INR 2 to 3** **INR > 3**	 Increase dose by 25% Repeat same dose Repeat same dose Decrease dose by 25% Decrease dose by 50-75% Hold Dose		
Day 4	**INR < 1.5** **INR 1.5 to 1.9** Δ INR = 0 to 0.2 Δ INR > 0.2 **INR 2 to 3** **INR > 3**	Increase dose by 25% Increase dose by 10 to 25% Repeat same dose Repeat same dose or decrease dose by 25% Hold Dose		
Day 5	INR < 1.5 INR 1.5 to 1.9 INR 2 to 3 INR > 3	Increase dose by 25 to 50% Repeat same dose or increase dose by 25% Repeat same dose or decrease dose 10 to 25% Hold Dose		
Day 6	INR < 1.5 INR 1.5 to 1.9 INR 2 to 3 INR > 3	Increase dose by 25 to 50% Increase dose by 25% Repeat same dose Decrease dose by 50% or hold dose		
Starting Day 7	Make adjustments based on total weekly dose (increase or decrease total weekly dose by 5-20% depending on current and target INR)			

- Δ in INR is change from previous day's INR
- If patient has been dosed different strengths each day, calculate the average dose and follow the above guidelines
- Round dose to the nearest tablet size
- In general, dosage adjustments should not exceed 2.5 mg or 50%

2012 ACCP Guidelines for Phytonadione (Vitamin K)

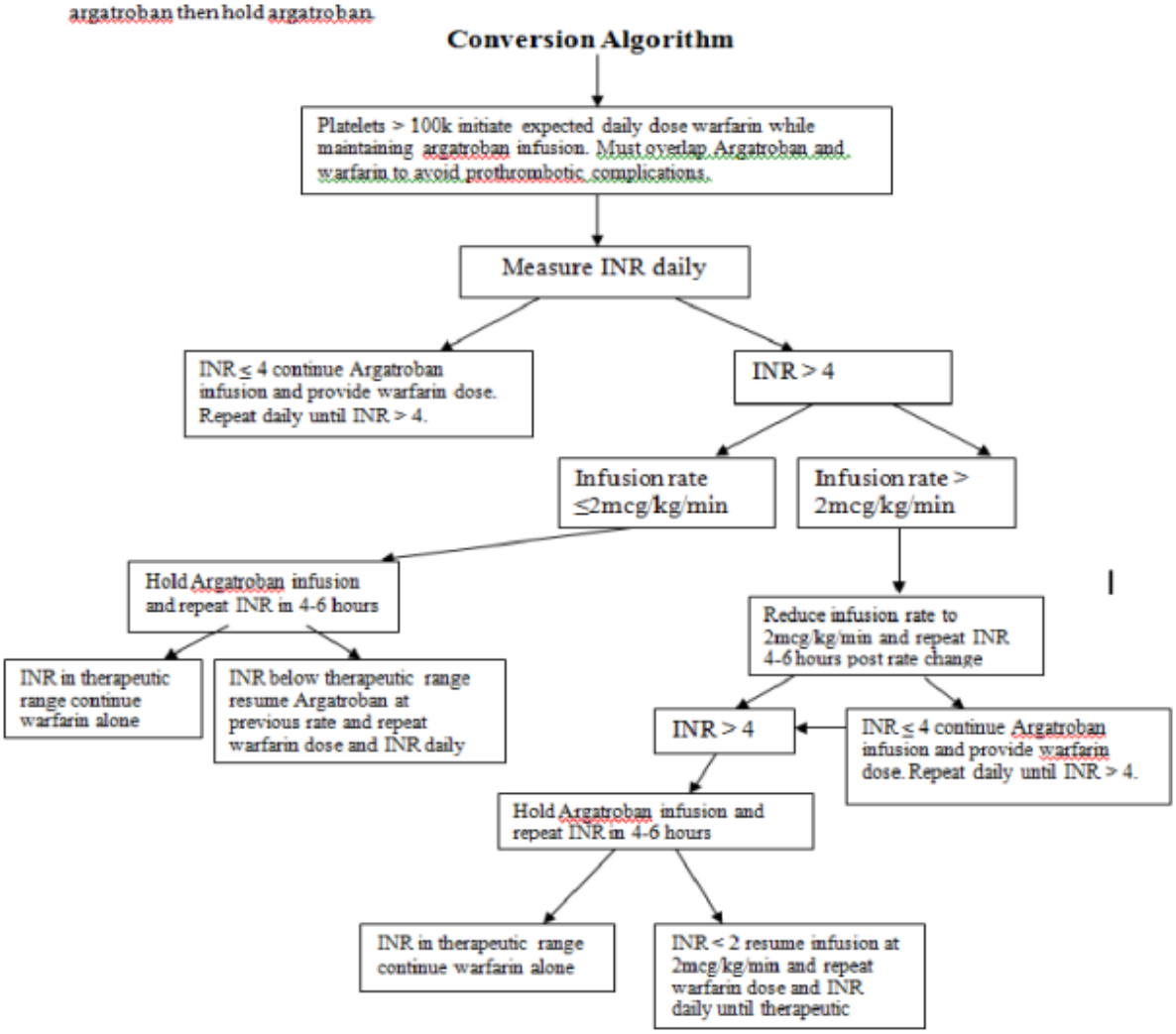
- **Physician order required for Vitamin K**
- Management of supratherapeutic INRs
  (based on vitamin K 5 mg tablet)

INR	Recommendation
Greater than therapeutic but < 4.5, no evidence of bleeding	Lower warfarin dose or omit a dose and resume at a lower dose
≥ 4.5 to ≤ 10 No evidence of bleeding	Omit 1 or 2 doses and resume therapy at a lower dose when INR is therapeutic
≥ 4.5 to ≤ 10 Rapid reversal for urgent surgery	Vitamin K 2.5 mg PO (INR reduction in 24 hours); if INR is still high, give an additional 1.25 to 2.5 mg PO
> 10 No evidence of bleeding	Hold warfarin and give Vitamin K 2.5 to 5 mg PO (INR reduction in 24 to 48 hours), give additional Vitamin K if necessary; resume warfarin at adjusted dose when INR is in therapeutic range
Major/life-threatening bleeding, regardless of INR	Hold warfarin and give 4 factor prothrombin complex concentrate (KCentra) and Vitamin K 5 to 10 mg by slow IV infusion. May repeat Vitamin K every 12 hours for persistent INR elevation

Addendum C

Northern Inyo Hospital – Department of Pharmacy
Guidelines for Conversion from Argatroban to Warfarin

- Argatroban prolongs PT/INR values but does not cause further reduction in Factor Xa activity than seen with warfarin alone
- Initiate warfarin **only** after substantial platelet recovery >100k
- Do not give a loading dose of warfarin
- Initiate warfarin at anticipated maintenance dose not to exceed 5mg
- Monitor PT/INR daily
- There are insufficient data available to recommend the duration of the overlap (most recommendations for 4-5 days)
- Per VTE Core Measure, overlap for at least 5 days. If within 5 days and INR therapeutic or supratherapeutic off of argatroban then hold argatroban.



Utilization Review Critical Indicators

2018

1. Discharge Disputes
2. Status Issues
3. Placement issues
4. Denials
5. Untimely Records Completions

Pediatric Critical Indicators

2018

1. Patient transfer to a higher level of care or referral center
2. Readmission to the hospital within 30 days for the same or related diagnosis
3. Respiratory or cardiac arrest (Apnea >15 seconds)
4. Death
5. Abuse
6. Dehydration requiring Intravenous Fluid
7. Neonates < 28 days, admitted to the Acute/Sub Acute Services
8. Length of stay exceeding 48 hours
9. IV/IM antibiotics
10. Nursing concerns

NORTHERN INYO HOSPITAL
STANDARDIZED PROCEDURE FOR
RN FIRST ASSISTANT

I. POLICY:

A. The RN First Assistant (RNFA) assists the attending surgeon during a surgical procedure by providing aid in exposure, hemostatis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.

B. Only an RN currently licensed in California, who meets all the criteria specified in Appendix A may perform this procedure.

The RNFA will be evaluated for continued competency 90 days after assuming this position and yearly thereafter. The evaluation will be done by means of a written performance evaluation based on the RNFA job description, will be done by the Surgery Nurse Manager, and will contain input from the appropriate attending surgeons based on the protocol section of this standardized procedure, chart review and their observations.

C. The RNFA may function under this standardized procedure when the following conditions are met:

1. The attending surgeon has determined that the RNFA can provide the type of assistance needed during the specific surgery.

II. PROTOCOL

The RNFA will:

1. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
2. Provide retraction by:
   a. Closely observing the operative field at all times.
   b. Demonstrating stamina for sustained retraction.
   c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
   d. Managing all instruments in the operative field to prevent obstruction of the surgeon’s view.
   e. Anticipating retraction needs with knowledge of the surgeon’s preferences and anatomical structures.

The RNFA will: (continued)

3. Provide hemostasis by:
   a. Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
   b. Sponging and utilizing pressure, as necessary.
   c. Utilizing suctioning techniques.
   d. Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
   e. Placing suture ligatures in the muscle, subcutaneous and skin layer.
   f. Placing hemoclips on bleeders, ad directed by the surgeon.

4. Perform knot tying by:
   a. Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
   b. Tying knots firmly to avoid slipping.
   c. Avoid undue friction to prevent fraying of suture.
   d. "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
   e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.

5. Perform dissection as directed by the surgeon by:
   a. Having knowledge of the anatomy.
   b. Demonstrating the ability to use the appropriate instrumentation.
   c. For abdominal surgery: dissection includes all layers to, but not, the peritoneum.

6. Provide closure of layers by:
   a. Correctly approximating the layers, under direction of the surgeon.
   b. Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs. continuous; skin sutures vs. staples; subcuticular closure; horizontal mattress.
   c. Correctly approximating skin edges when utilizing skin staples or suture.

7. Assist the surgeon at the completion of the surgical procedure by:
   a. Affixing and stabilizing all drains.
   b. Cleaning the wound and applying the dressing.
   c. Assist with applying casts; splints, bulky dressings, abduction devices.

The RNFA practices within the appropriate limitations and may choose not to perform those functions for which she has not been prepared or for which she does not feel capable of performing.

The activities outlined are determined based on the experience and education of the RNFA. The performance of other activities in the role of RNFA is dependent on the ability of the RNFA to safely perform the activities under the direction of the surgeon in a competent manner.

IV. APPROVAL:

This standardized procedure has been approved for use at Northern Inyo Hospital by:

Chairman, Surgery Tissue Committee	Date
Chairman, Committee on Interdisciplinary Practice	Date
Chief of Staff	Date
Administrator	Date
President, Board of Directors	Date

NORTHERN INYO HOSPITAL
STANDARDIZED PROCEDURE FOR
RN FIRST ASSISTANT

APPENDIX A

I. A registered nurse who is approved as a RNFA at NIH may function as first assistant if all of the following conditions exist.

1. Currently licensed as an RN in California.

2. Demonstrated proficiency in perioperative nursing practice as both scrub and circulator for at least two years, and currently effectively fulfilling the role of Surgery RN at NIH.

3. Successful completion of a course in RN First Assisting through an accredited program; one which uses the AORN Core Curriculum for the RNFA as a foundation. (A copy of the certificate of completion will be placed in the RNFA's personnel file.)

4. Current CNOR (Certified Nurse in the Operating Room), or obtains this within the first year of employment as RNFA.

5. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that is unique to functioning as a RNFA.

6. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the RNFA assists.

7. Demonstrated ability to function effectively and harmoniously as a team member.

8. Able to perform CPR; ACLS/PALS completion.

9. Able to perform effectively in stressful and emergency situations.

II. Nurses who have been approved to perform this standardized procedure are:

Name	Approval Date

PURPOSE
To outline the methodology for the medical screening examination of the obstetric patient by the RN.

POLICY
I. Procedure to be performed
   A. Standardized procedure for medical screening examination for the obstetrical patient performed by a registered nurse (RN) who is determined qualified by the Hospital's Medical Staff Bylaws, Rules and Regulations and approved by the Hospital's Governing Board, in compliance with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) 42 U.S.C., Section 1395, Tag A406.

II. Responsible Party
   A. A physician or Certified Nurse Midwife (hereafter, "provider") on the hospital medical staff is available for consultation to certify the labor evaluation.

   B. A medical screening examination may be performed by a Perinatal RN certified to perform medical screening examinations following this standardized procedure.

   C. The RN must successfully complete an initial competency validation involving two validations that are signed either by a provider or a qualified nurse preceptor (who has completed 5 validations). Original documentation is to be kept on file.

III. Contraindications to performing this procedure: Patient Refusal.
IV. Conditions for Provider Consultation and Orders
   A. All pregnant women presenting to the obstetrical department for care will receive a Medical Screening Examination and Assessment of Labor when requested without discrimination and regardless of their ability to pay.

   B. Following examination and assessment of the patient, the RN will communicate with the provider to apprise him/her of the findings. Based thereon, the provider will either concur with the assessment of the RN, or will present to the hospital to further evaluate the patient themselves.

   C. If the RN determines that a woman is not in labor, a provider must certify the diagnosis either through telephone consultation or physical examination of the patient. If telephone consultation is the means utilized to satisfy this requirement, documentation within the patient charts must be in accordance with the hospital Conditions of Participation (CoP) at 42 CFR §482.24(c)(1).

   D. A provider must be notified immediately if:
      a. Delivery is imminent. Preparations should be made for immediate delivery.

b. Complications or abnormal assessments arise during the patient' assessment. Such problems include:
   i. Fever, signs of infection
   ii. Excessive vaginal bleeding (more than spotting)
   iii. Elevated blood pressure
   iv. Hyperreflexia
   v. Non-vertex presentation
   vi. Tetanic contraction pattern
   vii. Non-reactive NST, Category 3 or worsening Category 2 strip
   viii. Premature gestation presenting in labor
   ix. Ruptured membranes

IV. Review Process
A. Quality improvement monitoring of this standardized procedure is ongoing.
B. Quality indicators developed and applied to all obstetrical patients, and chart audits will be performed for the following:
   Births occurring outside of a hospital facility, following a Medical Screening Exam by a RN

PROCEDURE

I. Who can perform this procedure?
A. Only Northern Inyo Hospital certified Perinatal RN's or providers may perform this standardized procedure.

II. Equipment
A. Sterile gloves
B. Lubricant
C. Electronic Fetal Monitor
D. BP cuff
E. Thermometer
F. Reflex hammer
G. Slides/microscope for fern testing

III. Validate appropriate patient selection criteria:
A. Patient must be an obstetric patient presenting for rule-out labor
B. Patient must give consent.
C. Patient must have absence of complications as listed under Policy III. D.b.

IV. Explain procedure to patient

V. If delivery is imminent, CALL THE PROVIDER and prepare for immediate delivery.

VI. If delivery is not imminent, continue assessment which will include but is not limited to:
A. Gravida, parity, EDC
B. Chief compliant/reason for visit
C. Review of prenatal record if available, obstetric history, and risk factors

D. Fetal movement
E. Evaluation of fetal heart rate and patterns appropriate for gestational age
F. Uterine contraction patterns
G. Labor status:
    a. Cervical dilation, effacement, and fetal station (unless contraindicated)
    b. Presenting part
    c. Status of membranes
H. Evaluation of urine for protein
I. Any other associated information

VII. Continue examination to assess, labor progress, and fetal wellbeing.

VIII. Maternal Infection
A. If temperature is 100.4 or above:
    a. Suspect infection – CALL PROVIDER
    b. Assess for other abnormal findings such as elevated blood pressure or excessive bleeding. If present – CALL PROVIDER.
    c. Determine proteinuria and check reflexes. If abnormal – CALL PROVIDER.
B. If temperature is normal, include this information with report to provider when total assessment is completed.

IX. Assessment of Labor Progress
A. Abdominal palpation and EFM monitoring
B. Assess uterine contraction pattern noting:
    a. Frequency
    b. Duration
    c. Intensity
    d. Resting tone
C. If normal, include this information with report to provider when total assessment is completed.
D. Potential complications may include but are not limited to:
    a. Preterm gestation
    b. Tetanic contraction pattern.
E. If potential complications are present – CALL PROVIDER
F. Vaginal examination:
    a. Determine the membrane status
        i. Intact or ruptured
        ii. Color, odor, or amount
        iii. Include this information with report to provider when total assessment is completed.
        iv. Digital cervical examination should not be performed in patients less than 36.0 weeks gestation, in cases of known or suspected placenta previa,

active vaginal bleeding, or with rupture of membranes, prior to receiving an order to do so by the provider

b. Determine presenting part
    i. If cephalic, include this information with report to provider when total assessment is completed.
    ii. If abnormal, CALLPROVIDER
c. Determine the state of the cervix:
    i. Effacement
    ii. Dilation
    iii. Station
d. If normal, include this information with report to provider when total assessment is completed
e. If abnormal, CALL PROVIDER

G. Assess bleeding:
    a. CALL PROVIDER if bleeding is more than spotting
    b. If normal, include this information with report to provider when total assessment is completed.

H. Assessment of fetal wellbeing
    a. Identify fetal heart rate pattern with application of an electronic fetal monitoring system or Doppler, if indicated.
    b. (2)Utilizing NICHD criteria and nomenclature assess NST reactivity or strip Category.
    c. If NST is non-reactive or if strip is Category 3 or worsening Category 2, CALL PROVIDER

I. At the completion of the medical screening examination, the RN will report to the patient's provider, by phone or in person, the findings of the examination and any other pertinent information before any further procedures are performed. Regardless of the assessment, any patient meeting the following criteria will be examined, in person, by a provider prior to discharge home:
    a. No prenatal care
    b. Maternal temperature ≥100.5(F), of uncertain etiology
    c. Altered level of consciousness
    d. Active vaginal bleeding
    e. Rupture of membranes
    f. Category 3 or worsening Category 2 strip
    g. Major maternal trauma.
J. In regards to a patient who is determined to not be in labor but needs additional evaluation to rule out an emergency condition: This patient will be seen in the Emergency Department and be provided with a medical screening examination to rule out other medical conditions prior to being discharged home. Prior to transfer back to the

Emergency Department, the L&D RN will report to the on-call provider, the findings of the labor examination and any other pertinent information. This RN will also call report to the Emergency Department RN and/or the Emergency Department Attending provider to inform them of the patient's impending return to the Emergency Department.

X. Documentation
   A. Patient assessment, including fetal assessment, will be documented in the EHR according to department policy.

REQUIREMENTS FOR MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT

XI. Minimal Education/Training
   A. Selected RNs will have successfully completed the hospital competency for performing Medical Screening Examination of the Obstetric Patient.

XII. Expertise
   A. Selected RNs will possess:
      a. Current California Registered Nurse (RN) license
      b. Current NRP and BLS certifications
      c. Experience in direct patient care with laboring patients as a RN
      d. Successful completion of annual antepartum and intrapartum continuing education per department requirements
      e. Completion of electronic fetal monitoring program (Intermediate or Advanced Fetal Monitoring) every two years.

XIII. Initial Evaluation
   A. Successfully complete the Northern Inyo Hospital Medical Screening Exam test with 85% accuracy.
   B. Successfully complete at least two (2) different obstetric patient medical screening examinations under the observation of the provider preceptor or a qualified nurse preceptor.
      a. A qualified "nurse preceptor" is a RN who may validate the competency of another RN to perform this procedure. A nurse preceptor must have completed at least five (5) obstetric patient medical screening examinations.
      b. Determined competency must be documented on the Medical Screening
      c. Examination of Obstetric Patient Competency Validation Tool.

XIV. Ongoing Evaluation
   A. Annual competency validation to be performed.

Approval	**Date**
CCOC	10/23/17
Interdisciplinary Practice Committee	
Perinatal Pediatrics Committee	10/20/17

Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	2/15/17

Developed: 11/07
Reviewed: 11/08, 9/12
Revised: 10/17
Supersedes:
Index Listings:

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT PERFORMED BY THE REGISTERED NURSE

NAME/TITLE: _____ DATE: _____

Measurement of Competency	Meets Requirements Date	Needs Additional Assistance	Comments
1) Describes patient selection criteria and instances of provider notification.			
a) Imminent delivery			
b) Fever, signs of infection			
c) Excessive vaginal bleeding			
d) Elevated blood pressure			
e) Hyperreflexia			
f) Non-vertex presentation			
g) Tetanic contraction pattern			
h) Non-reactive NST			
i) Category 3 strip			
j) Worsening Category 2 strip			
k) Premature gestation presenting in labor			
l) Ruptured membranes regardless of gestational age.			
2) Explains procedure to patient			
3) Assembles equipment			
4) Performs assessment in systematic format			
a) Chief complaint			
b) Obstetric history			
c) Labor status and progress			
d) Fetal wellbeing			
5) Communicates findings of examination and any other pertinent information to provider.			
6) Documents appropriately in the EHR			

_____ _____

Employee Signature Provider/Qualified RN Preceptor Signature

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT
PERFORMED BY REGISTERED NURSE

QUALITY IMPROVEMENT DATA

MEDICAL RECORD #_____

C.C.: _____

DATE: _____

1. Patient Selection
   - ❑ Meets criteria
   - ❑ Does not meet criteria. Describe: _____
2. Maternal Assessment
   - ❑ All systems WNL
   - ❑ Presence of complications
3. Fetal Assessment
   - ❑ Reassuring FHR
   - ❑ Non-reassuring tracing

   Describe: _____
4. Documentation
   - ❑ Electronic Medical Record
5. Provider Contacted:
   - ❑ Yes Who: _____
   - ❑ No Why not: _____
6. Outcome
   - ❑ Birth Outside of Hospital
   - ❑ Maternal complications Describe: _____
   - ❑ Neonatal complications Describe: _____
   - ❑ Admission for labor
   - ❑ Discharged
   - ❑ Other:_____

PATIENT CARE SERVICES DIVISION

NAME/TITLE: _____DATE: _____

COMPETENCY: Medical Screening Examination for the Obstetrical Patient Performed by the Registered Nurse

*Evaluation Method Codes: O=Observation; M=Module; T=Test; RD=Return Demonstration; C-Computer

Measurement of Competency	Meets Requirements Date	Needs Additional Assistance	*Evaluation Methods/ Comments
1. Successfully completes module and post-test with 100% accuracy.			
2. Describes patient selection criteria and instances			

Measurement of Competency	Meets Requirements Date	Needs Additional Assistance	*Evaluation Methods/ Comments
of physician notification.			
a. Imminent delivery			
b. Fever, signs of infection			
c. Excessive vaginal bleeding			
d. Elevated blood pressure			
e. Abnormal deep tendon reflexes			
f. Non-vertex presentation			
g. Uterine hyperstimulation			
h. Lack of uterine activity			
i. Tetanic contraction			
j. Non-reassuring fetal heart rate			
k. Premature gestation			
l. Ruptured membranes regardless of gestational age.			
3. Explains procedure to patient			
4. Assembles equipment			
5. Performs assessment in systematic format			
a. Chief complaint			
b. Obstetric history			
c. Labor status and progress			
d. Maternal hydration			
e. Fetal wellbeing			
6. Communicates findings of examination and any other pertinent information to physician.			
7. Documents appropriately on the Birthing Center Log Book and on the Obstetrical Assessment Record.			

_____

Employee Signature Instructors Signature

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT
PERFORMED BY REGISTERED NURSE

QUALITY IMPROVEMENT DATA

MEDICAL RECORD #_____

AGE: _____

C.C.: _____

DATE: _____

1. Patient Selection
   - ❑ Meets criteria
   - ❑ Does not meet criteria. Describe: _____
2. Maternal Assessment
   - ❑ All systems WNL
   - ❑ Presence of complications
3. Fetal Assessment
   - ❑ Reassuring FHR
   - ❑ Non-reassuring tracing

   Describe: _____
4. Documentation
   - ❑ Log Book ❑ Medical Record
5. Physician Contacted:
   - ❑ Yes Who: _____
   - ❑ No Why not: _____
6. Outcome
   - ❑ Birth Outside of Hospital
   - ❑ Maternal complications Describe: _____
   - ❑ Neonatal complications Describe: _____

NOT A PART OF PERMANENT MEDICAL RECORD
APPROVAL

This standardized procedure has been approved for use at Northern Inyo Hospital by:

_____	_____
Chairman, Perinatal/Pediatrics Committee	Date
_____	_____
Chairman, Interdisciplinary Practice Committee	Date
_____	_____
Chief of Staff	Date
_____	_____
Administrator	Date
_____	_____
President, Board of Directors	Date

Registered Nurses who have been approved to perform this standardized procedure are:

_____	_____
	Date
_____	_____
	Date
_____	_____
	Date

_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date
_____	_____ Date

NORTHERN INYO HOSPITAL MEDICAL STAFF
STANDARDIZED PROCEDURE FOR
CERTIFIED NURSE MIDWIVES
FIRST ASSISTING DURING CESAREAN SECTIONS

I. POLICY:

A. The Certified Nurse Midwife (CNM) assists the attending surgeon during a cesarean section by providing aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.

B. Only a CNM currently licensed in California, who meets all of the criteria specified in Appendix A may perform this procedure.

The CNM will be evaluated for continued competency 90 days after assuming this expanded role and yearly thereafter. The evaluation will be performed by a physician and will contain input from the appropriate attending surgeon(s) based on this standardized procedure, chart review, and their observations.

C. The CNM may function under this standardized procedure only when the following conditions are met:
1. The attending surgeon has determined that the CNM can provide competent assistance during a cesarean section.
2. The CNM functions under the direct supervision of the attending surgeon.

II. STANDARDIZED PROCEDURE:

The CNM will:

A. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.

B. Provide retraction by:
1. Closely observing the operative field at all times.
2. Demonstrating stamina for sustained retraction.
3. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
5. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.

C. Provide hemostasis by:
1. Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
2. Sponging and utilizing pressure, as necessary.
3. Utilizing suctioning techniques.
4. Applying clamps on superficial vessels and tying or applying electrocoagulation to them, as directed by the surgeon.
5. Placing suture ligatures in the muscle, subcutaneous and skin layer.

D. Perform knot tying by:
   1. Having knowledge of the basic techniques of knot tying to include the two-handed tie, the one-handed tie, and the instrument tie.
   2. Tying knots firmly to avoid slipping.
   3. Avoiding undue friction to prevent fraying of suture.
   4. "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
   5. Approximating tissue rather than pulling tightly to prevent tissue necrosis.

E. Perform dissection as directed by the surgeon by:
   1. Having knowledge of the anatomy.
   2. Demonstrating the ability to use the appropriate instrumentation.
   3. For abdominal surgery: dissection includes all layers down to, but not including, the peritoneum.

F. Provide closure of layers of tissue as directed by the surgeon, including the fascia, the subcutaneous tissue, and the skin by:
   1. Correctly approximating the layers, under direction of the surgeon.
   2. Demonstrating knowledge of the different types of closures, including but not limited to: interrupted vs. continuous, skin sutures vs. staples, subcuticular closure, and horizontal mattress.
   3. Correctly approximating skin edges when utilizing skin staples or suture.

G. Assist the surgeon at the completion of the surgical procedure by:
   1. Affixing and stabilizing all drains.
   2. Cleaning the wound and applying the dressing.

The CNM practices within the appropriate limitations and may choose not to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

APPENDIX A

I. A CNM with Medical Staff privileges at NIH may function as a first assistant during cesarean sections if all of the following conditions have been met:

A. Currently licensed as a CNM in the state of California.

B. Successful completion of an accredited Certified Nurse Midwife program.

C. CNMs who have not been educated and trained as a first assistant prior to or during their midwifery education must complete a formal continuing education course approved by the American College of Nurse-Midwives (ACNM).

D. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a CNM.

E. Demonstrated knowledge of surgical anatomy, physiology, and the cesarean section procedure.

F. Demonstrated ability to function effectively and harmoniously as a team member.

G. Able to perform CPR; ACLS completion preferred.

H. Able to perform effectively in stressful and emergency situations.

APPROVALS SIGNATURES	DATE
Chair, Surgery, Tissue, Transfusion and Anesthesia Committee	2/19/15
Chair, Interdisciplinary Practice Committee	2/2/15
Chair, Medical Executive Committee	3/3/2015
President, NICLHD Board of Directors	4-20-15

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

CNM Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

Procedure	
Signature of Supervising Physician	Date

NORTHERN INYO HOSPITAL MEDICAL STAFF
PROTOCOL FOR
PHYSICIAN ASSISTANT IN THE OPERATING ROOM

I. POLICY:

A. The Physician Assistant (PA) assists the attending surgeon during a surgical procedure by providing aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.

B. Only a PA currently licensed in California, who meets all the criteria specified in Appendix A may perform this procedure. Knowledgeable regarding PA limitations and practices within these.

The PA will be evaluated for continued competency 90 days after assuming this position and yearly thereafter. The evaluation will be done by a physician and will contain input from the appropriate attending surgeon(s) based on this protocol, chart review and their observations.

C. The PA may function under this protocol only when the following conditions are met:

1. The attending surgeon has determined that the PA can provide the type of assistance needed during the specific surgery.
2. The PA functions under the supervision of the Attending Surgeon. The attending surgeon does not need to be physically present in the operating room for those portions of the procedure (usually setup and final closure) which in the judgment of the attending surgeon the PA may safely do without direct and in person supervision. The attending surgeon must be able to be present immediately if needed and must have a reliable way to be contacted and summoned, such as a cell phone, if needed. Specifically, the attending surgeon may be in such places as the recovery room, the pre op area, the wards of the hospital, an on campus office, or the ER.

II. PROTOCOL

The PA will:

1. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
2. Provide retraction by:
   a. Closely observing the operative field at all times.
   b. Demonstrating stamina for sustained retraction.
   c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
   d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
   e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
3. Provide hemostasis by:
   a. Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
   b. Sponging and utilizing pressure, as necessary.

c. Utilizing suctioning techniques.
d. Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
e. Placing suture ligatures in the muscle, subcutaneous and skin layer.
f. Placing hemoclips on bleeders, as directed by the surgeon.

4. Perform knot tying by:
   a. Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
   b. Tying knots firmly to avoid slipping.
   c. Avoiding undue friction to prevent fraying of suture.
   d. "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
   e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.

5. Perform dissection as directed by the surgeon by:
   a. Having knowledge of the anatomy.
   b. Demonstrating the ability to use the appropriate instrumentation.
   c. For abdominal surgery: dissection includes all layers to, but not, the peritoneum.

6. Provide closure of layers of tissue as directed by the surgeon; sutures fascia., subcutaneous tissue and skin by:
   a. Correctly approximating the layers, under direction of the surgeon.
   b. Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs. continuous; skin sutures vs. staples; subcuticular closure; horizontal mattress.
   c. Correctly approximating skin edges when utilizing skin staples or suture.

7. Assist the surgeon at the completion of the surgical procedure by:
   a. Affixing and stabilizing all drains.
   b. Cleaning the wound and applying the dressing.
   c. Assisting with applying casts; splints, bulky dressings, abduction devices.

The PA practices within the appropriate limitations and may choose not to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

APPENDIX A

I. A Physician Assistant who is approved as a PA at NIH may function as first assistant if all of the following conditions exist.

1. Currently licensed as a PA in California.

2. Successful completion of an accredited Physician Assistant program. (A copy of the certificate of completion will be placed in the PA's personnel file and the Medical Staff credentials file.)

3. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a PA.

4. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the PA assists.

5. Demonstrated ability to function effectively and harmoniously as a team member.

6. Able to perform CPR; ACLS completion preferred.

7. Able to perform effectively in stressful and emergency situations.

APPROVALS SIGNATURES	DATE
Chair, Surgery, Tissue, Transfusion and Anesthesia Committee	
Chair, Interdisciplinary Practice Committee	
Chair, Medical Executive Committee	
President, NICLHD Board of Directors	

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date

PA Authorized to Perform this Protocol	Date of Approval by District Board of Directors
Signature of Supervising Physician	Date