Northern Inyo Hospital

August 16 2017 Regular Meeting

August 16 2017 Regular Meeting - August 16 2017 Regular M

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

August 16, 2017 at 5:30 p.m.

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

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business
   A. Laboratory Policy and Procedure, *Gastric Occult Blood Testing* (*action item*).
   B. Laboratory Policy and Procedure, *Hemoccult Sensa – Fecal Occult Blood* (*action item*).
   C. Policy and Procedure approval, Emergency Paging (*action item*).
   D. Hospital wide Policy and Procedure annual approvals, Attachment A to Agenda (*action item*).
   E. District Board Resolution 17-03, LAIF Fund Authorization (*action item*).

Consent Agenda (action items)

4. Approval of minutes of the July 19, 2017 regular meeting
5. 2013 CMS Validation Survey Monitoring, August 2017
6. Financial and Statistical Reports for the period ending June 30, 2017

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7. Data and Information Committee report (*information item*).
8. Quarterly Compliance report (*information item*).
9. Chief Executive Officer report (*information item*)
   - *Medical Staff Services Pillars of Excellence for 2016/2017 Fiscal Year*
10. Chief Operating Officer report (*information item*).
11. Chief Financial Officer report (*information item*).
12. Chief Nursing Officer Report (*information item*).
13. Chief Human Resources Officer Report (*information item*).

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

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

- *Childbirth Photography/Videotaping*
- *Plan to Eliminate or Substantially Reduce Medication-Related Errors – MERP 2017*
- *Anesthesia in Ancillary Departments*
- *Hydrotherapy Pool Lippincott Procedure with Critical Notes and Consent*
- *Fall Prevention and Management (with attachments)*
- *Patient Transfer/Discharge to Another Facility*
- *Medical Staff and Allied Health Professional Application Fee Processing*

B. Core Privilege Forms by Service (*action items*)

- Pediatrics
- Orthopedic Surgery
- General Surgery

C. Annual Reviews (*action item*)

- Pediatric Critical Indicators 2017

D. Medical Staff Appointment/Privileging (*action item*)

- Arash Radparvar, MD (*radiology – provisional active staff*)

E. Temporary Privileges for 60 service days in calendar year 2017, except where noted (*action items*):

- William Feske, MD (*Bishop Radiology Group*) – 90 calendar days
- Brian Mikolasko, MD (*hospitalist - locums*)
- Kathy Burck, MD (*hospitalist - locums*)
- Louisa Salisbury, MD (*Pediatrics – locums*) – pending the submission of proof of insurance

F. Extension of Temporary Privileges (*action item*)

- Wilbur Peralta, MD (*hospitalist*) – extension of temporary privileges from 8/31/17 to 12/31/17 to provide necessary coverage of the hospitalist service

G. Advancement (*action item*)

- Jay K. Harness, MD (*breast surgery*) – advancement from provisional to full active staff

H. Resignations (*action items*)

- Carolyn Saba, MD (*anesthesiology*) – effective 7/26/17
- Shruti Ramakrishna, MD (*family medicine*) – effective 9/5/17
- Manish Pandya, MD (*internal medicine/hospitalist*) - effective 9/1/17

16. Reports from Board members (*information items*).
17. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
    B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 2 matters pending (*pursuant to Government Code Section 54956.9*).
    C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
18. Return to open session and report of any action taken in closed session.
19. 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 HOSPITAL
POLICY AND PROCEDURE

Title: Gastroccult – Gastric Occult Blood Testing	
Scope: Laboratory	Manual: Hematology
Source: Hematology Coordinator	Effective Date:

I. PURPOSE

The Gastroccult test is a rapid screening test (CLIA waived) designed for detecting the presence of occult blood and determining the pH of gastric aspirate or vomitus. The Gastroccult slide test is used as an aid in the diagnosis and management of various gastric conditions which may be encountered in intensive care areas, including ER, ICU and Acute/Subacute Care (MedSurg). The identification of occult blood can be useful in the early detection of gastric trauma or deteriorating gastric conditions, while pH may be of use in evaluating antacid therapy.

II. PRINCIPLE

The Gastroccult slide includes a specially buffered guaiac test for occult blood. The active component of guaiac is guaiaconic acid which reacts with hydrogen peroxide and in the presence of heme which contains a peroxidative-type of catalyst, and produces a highly conjugated blue quinone compound. When a gastric specimen containing blood is applied to Gastroccult test paper, the hemoglobin from the lysed blood cells comes into contact with the guaiac. Application of Gastroccult developer causes a peroxides-like reaction which turns the test paper blue if blood is present. It is not to be considered conclusive evidence of the presence or absence of upper gastrointestinal bleeding. It is used as a preliminary screening aid and is not intended to replace other diagnostic procedures such as gastroscopic examination or X-ray studies. The Gastroccult slide includes a pH test based on the principle that certain dyes change color with changes in hydrogen ion concentration. The occult blood test is not affected by low pH. Gastroccult is free from interferences by normal therapeutic concentrations of cimetidine (Tagamet), iron or copper salts.

III. MATERIALS AND REAGENTS

- Gastroccult slides (test cards)
- Gastroccult developer
- Applicator sticks, pipette or syringe to transfer specimen to testing slide
- Stopwatch/timer

IV. STORAGE AND STABILITY

- Do not refrigerate or freeze slides or developer.
- Store kit and developer in controlled room temperature of 15 to 30°C (59 to 86°F).
- Do not store items near volatile chemicals or cleaning agents.
- Protect from heat and light.
- Slides and developer remain stable until the expiration date which appears on each slide and developer bottle. Date kit and developer with receiving date and open date.
- The developer bottle should be kept tightly capped when not in use.

V. SPECIMEN COLLECTION AND PRECAUTIONS

1. A gastric aspirate is obtained by nasogastric intubation or vomitus.
2. Use immediately or store in a clean container either plastic or glass up to 24 hours at a controlled room temperature 15 to 30°C (59 to 86°F).

Note: Nursing will follow instructions provided by Lippincott procedure(s) to collect specimens.

Title: Gastroccult – Gastric Occult Blood Testing	
Scope: Laboratory	Manual: Hematology
Source: Hematology Coordinator	Effective Date:

VI. TEST PROCEDURE

1. Open slide.
2. Apply **one (1) drop** of gastric sample to pH test circle and **one drop** to occult blood test area.
3. Determine pH of sample by visual comparison of test area to pH color chart **within 30 seconds** after sample application.
4. Apply **two (2) drops** of Gastroccult developer directly over the sample in the occult blood test area.
5. Read occult blood results **within 60 seconds**. The development of any trace of blue color in the test area is regarded as a positive result.
   Note: Some gastric samples may be highly colored and appear as blue or green on the test area. Test results should only be regarded as positive if additional blue is formed after the Gastroccult developer is added.
6. Record results on the testing form if applicable and in the patient's record.
7. Add **one (1) drop** of Gastroccult developer between the positive and negative performance monitor area. A blue color will appear in the positive area **within 10 seconds** and remain stable for 60 seconds.

VII. QUALITY CONTROL

The function and stability of the slides and developer are tested using the on-slide performance monitor feature located to the right of the sample testing area.

1. Quality control (QC) should be performed only after the patient test has been developed, read and interpreted.
2. The positive performance monitor area contains a hemoglobin-derived catalyst which, upon application of developer, will turn blue within 10 seconds. The color will remain stable for at least 60 seconds.
3. The negative performance monitor area contains no catalyst and should not turn blue upon application of the developer.
4. If the performance areas do not react as expected after application of the developer, the occult blood test result should be regarded as invalid.
5. Should the internal QC fail, call the manufacturer for troubleshooting steps.
6. External QC is not necessary as stated by the manufacturer.

VIII. RESULTING

1. DO NOT REPORT PATIENT RESULTS IF INTERNAL CONTROLS ARE INVALID!
2. Occult blood **negative** results – no detectable blue in the occult blood test area.
3. Occult blood **positive** results – any trace of blue in the occult blood test area.
4. Record results with the internal QC result and lot number of cards and developer as well as the expiration dates in the patient record.

IX. LIMITATIONS AND NOTES

A. Gastroccult tests are designed as an aid in the diagnosis and are not intended to replace other diagnostic procedures such as gastroscopic examination or X-ray studies.
B. Because this test is visually read and requires color differentiation, it should not be interpreted by people who are color-blind or visually impaired.

C. Patient specimens and all materials that come into contact with them should be handled as potentially infectious and disposed of with proper precautions.
D. Only use Gastroccult developing solution to develop the test.
E. It is expected that gastric aspirates from some individuals may give positive test results. Please see package insert for further explanation.
F. Many foods (e.g. incompletely cooked meat, raw fruits and vegetables) have peroxidase activity which can produce a positive Gastroccult test result. Thus, a positive test result does not always indicate the presence of human blood.
G. Gastroccult slides are designed to function reliably in the presence of low pH, high drug concentrations, metal ions or plant peroxidases in food. The interference (false-positive) from plant peroxidases, such as horseradish (HRP), is reduced with the Gastroccult test over other guaiac based testing cards.
H. Please see package insert for further details of possible interfering substances.

X. REFERENCES

1. Beckman Coulter Gastroccult Package Insert 03-2015

Approval	**Date**
Medical Director of the Laboratory	8/3/2017
Board of Directors	
Last Board of Directors Review	

Developed: 8/17
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Hemoccult Sensa – Fecal Occult Blood	
Scope: Laboratory	Manual: Laboratory
Source: Hematology Coordinator	Effective Date:

I. PURPOSE

The Hemoccult test is a rapid, qualitative method for detecting fecal occult blood which may be indicative of gastrointestinal disease. It is not a test for colorectal cancer or any other specific disease. It is used as an aid in detecting gastrointestinal bleeding in patients with iron deficiency anemia or recuperating from surgery, peptic ulcer, and ulcerative colitis.

II. PRINCIPLE

The Hemoccult test is based on the oxidation of guaiac by hydrogen peroxide to a blue-colored compound. The heme portion of hemoglobin, if present in the fecal specimen, has a peroxidase activity which catalyzes the oxidation of alpha guaiaconic acid (active component of guaiac paper) by hydrogen peroxidase (active component of the developer) to form a conjugated blue quinine compound.

III. MATERIALS AND REAGENTS

- Hemoccult Sensa slides (test cards)
- Hemoccult Sensa developer
- Applicator sticks

IV. STORAGE AND STABILITY

- Store slides and developer at 15 to 30°C (59 to 86°F).
- Do not refrigerate or freeze.
- Hemoccult slides and developer remain stable until manufacturer's expiration dates.
- Date kit and developer with a receiving date and open date.
- Do not store with volatile chemicals like ammonia, bleach, bromine, iodine, household cleaners.

V. SPECIMEN COLLECTION AND PRECAUTIONS

A. Acceptable specimens

1. A fresh stool specimen can be collected in a clean dry container.

NOTE: Nursing will follow instructions provided by Lippincott procedure(s).

B. Drug guidelines

1. For seven days before and during stool collection, non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen or aspirin (more than one adult aspirin per day) should be avoided.
2. Acetaminophen (Tylenol) can be taken as needed.
3. For three days before and during stool collection period, Vitamin C in excess of 250 mg a day from supplements and citrus fruit and juices should be avoided.

C. Diet guidelines

1. For three days before and during stool collection period, red meat (beef, lamb and liver) should be avoided.
2. A well balanced diet including fiber such as bran cereals, fruits and vegetables should be maintained.

Title: Hemoccult Sensa – Fecal Occult Blood	
Scope: Laboratory	Manual: Laboratory
Source: Hematology Coordinator	Effective Date:

NOTE: 100% of Recommended Dietary Allowance (RDA) of Vitamin C is 60 mg a day. Some iron supplements contain Vitamin C in excess of 250 mg.

VI. TEST PROCEDURE

1. Using the applicator stick, smear fecal material to the designated "A" and "B" windows on the front side of the testing card.
    - Only a very small amount of fresh fecal specimen, **thinly applied**, is necessary in preparing the slide. With side or flattened part of applicator stick apply fresh stool – scrape most of residual stool off.
    - Select sample from **two different sections** of fecal specimen.
    - A fresh stool specimen slightly contaminated with urine is acceptable, if it is know that the **urine is negative for blood and/or hemoglobin**.
    - **DO NOT** use sample if blood is visible.
2. Close the front flap.
3. Wait **3-5 minutes** after the sample application before developing the test.
4. Open the flap in the back and apply **2 drops** of Hemoccult Sensa developer over each smear.
5. Interpret **within 60 seconds**.
6. **Any trace of blue** on or at the edge of the smear is **positive** for occult blood.

Note: Some specimens have a high bile content which causes the feces to appear green. A distinct green color (no blue), appearing on or at the edge of the smear within 60 seconds after adding the developer should be interpreted as negative for occult blood. A blue-green color should be interpreted as positive for occult blood.

VII. QUALITY CONTROL

Quality control areas must be developed on every slide. They are located under the sample area on the developing side of the slide. Perform quality performance (quality control) after patient has been developed and read.

1. Apply 1 drop of Hemoccult Sensa developer between the positive and negative test areas after the test is developed, read and interpreted as negative or positive.
2. Read result within 10 seconds.
3. If the slide and developer are functional, a **blue** color will appear in the **positive performance monitor** (QC) area and **no blue** will appear in the **negative performance monitor** (QC) area.

Note: In the event that the performance monitor areas do not react as expected after applying developer, the test slide should be discarded and a new test slide should be obtained.

4. External QC is not necessary as stated by the manufacturer.

VIII. RESULTING

1. DO NOT REPORT PATIENT RESULTS IF INTERNAL CONTROLS ARE INVALID!
2. Normal results are negative – no blue color.
3. Any blue is considered positive (occasionally, a light blue discoloration may be noticed on the guaiac test paper). This discoloration does not affect the accuracy or performance of the test when it is developed and interpreted according to the discolored slide, the blue background color migrates outward. A blue ring forms at the edge of the wetted area, leaving the guaiac paper

around the fecal smear off-white in color. Any blue on or at the edge of the smear is positive for occult blood.

4. Record results with the internal QC result and lot number of cards and developer as well as the expiration dates in the patient record.

IX. LIMITATIONS AND INTERFERENCES

A. Substance that can cause **false-negative** test results:
   a. Ascorbic acid (Vitamin C) in excess of 250 mg/day.
   b. Excessive amounts of Vitamin C enriched foods (citrus fruits and juices).

B. Substance that can cause **false-positive** test results:
   a. Red meat (beef, lamb, liver).
   b. Aspirin (>325 mg/day), and other non-steroidal anti-inflammatory drugs such as ibuprofen, indomethacin and naproxen.
   c. Corticosteroids, phenylbutazone, reserpine, anticoagluants, antimetabolites and cancer chemotherapy drugs.
   d. Alcohol in excess.
   e. The application of antiseptic preparations containing iodine (povidone/iodine mixture) to anal area.

NOTE: Dietary iron supplements will not produce false-positive results.

X. EXPECTED RESULTS

In general, screening asymptomatic individuals, a positivity rate of approximately 3-7% was obtained. The false positive rate for colorectal disease was 1-3% depending on the compliance to collection requirements.

XI. REFERENCES

1. Beckman Coulter Hemoccult Sensa Package Insert 06-2015

Approval	Date
Medical Director of the Laboratory	8/3/2017
Board of Directors	
Last Board of Directors Review	

Developed: 8/17
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Paging	
Scope: NIHD	Manual:
Source: CEO	Effective Date:

PURPOSE:

1. To be used as a guide for staff to correctly initiate the emergency paging system.
2. To notify hospital staff when an emergency situation exists.
3. To quickly obtain specially trained staff when an emergency occurs.

PROCEDURE:

1. To initiate an emergency page from a phone:
   a. Dial "2400". This is the code phone.
   b. State the nature of the emergency and location, e.g., Code Blue, ICU, room 3.
2. To initiate a self-overhead page through the hospital intercom from a phone:
   a. Dial "71"
   b. Announce the emergency page three (3) times over the hospital intercom.
3. When the CODE is secured:
   a. Dial 2400
   b. State code secure along with the nature of the code that is secured. E.g., Code Blue, ICU, room 3 secured. The page will be announced over the intercom three times.

EMERGENCY PAGES IN THIS HOSPITAL:

a. See Northern Inyo Hospitals' "Safety/ Security Rainbow Chart" for how to call a specific code and what those codes are used for.

CODE BLUE BUTTONS

Code blue buttons should be pressed to initiate the voice paging system that gives the location of the code.
Code blue buttons are located in the following areas:

Acute/Sub Acute Department: Every patient room
Emergency Department: Every patient room including triage
PACU: Every patient room
Surgery: All surgery suites
Diagnostic Imaging: CT and MRI
Intensive Care Unit: Every patient room
Perinatal Department: Every patient room including triage and Postpartum
Nursery
Perinatal exam room

Approval	Date
CCOC	6/5/17
Safety Commitee	7/12/17
Board of Directors	
Last Board of Director Review	4/19/17

Revised: 8/86, 10/97 5/17la
Reviewed: 6/90 and 12/94, 11/97, 2/98' 8/2000 BM; 03/04/04 CK; 02/2006, 8/09 LB; 6/11mc; BS 9/12, 3/13bs
Index Listings: Emergency Paging System; Paging System, Emergency

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Paging	
Scope: NIHD	Manual:
Source: CEO	Effective Date:

COMPLIANCE POLICIES

ANNUAL APPROVALS

1. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
2. False Claims Act Employee Training and Prevention Policy
3. Regulatory Survey Security Policy and Procedure
4. Governmental Agent Services
5. Employee Access to His or Her Own Protected Health Information

	POLICY & PROCEDURES TO THE BOARD	AUGUST, 2017			
	ENVIRONMENTAL SERVICES				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Procedures: Room/Building Components: Floor Care (Taski Method, Mop Method, Floor Polishing	8/16/2017			
2	Cleaning Procedures: Room/Building Components: Floor Finish Applications	8/16/2017			
3	Cleaning Procedures: Room/Building Components: Floor Finish Stripping	8/16/2017			
4	Cleaning Procedures: Room/Building Components: Intake Vents	8/16/2017			
5	Cleaning Procedures: Room/Building Components: Light Fixtures	8/16/2017			
6	Cleaning Procedures: Room/Building Components: Machine Buffing	8/16/2017			
7	Cleaning Procedures: Room/Building Components: Machine Scrubbing	8/16/2017			
8	Cleaning Procedures: Room/Building Components: Vacuuming	8/16/2017			
9	Cleaning Procedures: Room/Building Components: Walls	8/16/2017			
10	Cleaning Procedures: Room/Building Components: Wet Mopping	8/16/2017			
11	Cleaning Procedures: Room/Building Components: Windows	8/16/2017			
12	Cleaning Procedures: Specialized Areas: Central Supply	8/16/2017			
13	Cleaning Procedures: Specialized Areas: Nursery	8/16/2017			
14	Cleaning Procedures: Specialized Areas: Operating Rooms, Between Cases	8/16/2017			
15	Cleaning Procedures: Specialized Areas: Perinatal Unit	8/16/2017			
16	Cleaning Procedures: Specialized Areas: Surgical Suite (In-Depth)	8/16/2017			
17	Cleaning Procedures: Various Non-Patient Care Equipment	8/16/2017			

POLICY AND PROCEDURE ANNUAL APPROVALS

FISCAL SERVICES

1. Hospital Furnished Uniforms

HUMAN RESOURCES
POLICY AND PROCEDURES APPROVAL LIST
AUGUST 2017

1. ACKNOWLEDGMENT FORM
2. AT-WILL DISCLAIMER STATEMENT
3. EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS
4. EQUAL EMPLOYMENT OPPORTUNITY
5. HARASSMENT BY EMPLOYEES
6. EXEMPT EMPLOYEES
7. PAY DISTRIBUTION
8. PAY SCALE AND PAY ADJUSTMENTS
9. PUNCH DETAIL REPORT
10. ZERO PAY

NORTHERN INYO HEALTHCARE DISTRICT

DISTRICT BOARD RESOLUTION 17-03

WHEREAS, pursuant to Chapter 730 of the statutes of 1976 Section 16429.1 was added to the California Government Code to create a Local Agency Investment Fund in the State Treasury for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District does hereby find that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with the provisions of Section 16429.1 of the Government Code for the purpose of investment as stated therein as in the best interests of the Northern Inyo Healthcare District,

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of the Northern Inyo Healthcare District does hereby authorize the deposit and withdrawal of Northern Inyo Healthcare District monies in the Local Agency Investment Fund in the State Treasury in accordance with the provisions of Section 16429.1 of the Government Code for the purpose of investment as stated therein, and verification by the State Treasurer's Office of all banking information provided in that regard.

BE IT FURTHER RESOLVED by the Northern Inyo Healthcare District Board of Directors, meeting in regular session this 16th day of August, 2017 that the Chief Executive Officer Kevin S. Flanigan, MD, MBA and Chief Financial Officer Kristina Gritsutenko, or their successors in office, shall be authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund.

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

_____ _____

Peter Watercott, President — Date
Northern Inyo Healthcare District

Attest: _____ _____

M.C. Hubbard, Secretary — Date
Northern Inyo Healthcare District

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT / NORTHERN INYO HEALTHCARE DISTRICT

DISTRICT BOARD RESOLUTION 16-02

Whereas Northern Inyo County Local Hospital District desires to expand services beyond that of a local primary care 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 in the Northern Inyo County Local Hospital District and

Whereas to provide such services and access a "Healthcare District' must be the organizational structure and

Whereas legal counsel has provided the necessary documents to become a 'Healthcare District' and

Whereas the Board of Directors has voted to approve the adoption of these documents and

Whereas this action is intended to allow the Board of Directors to now govern a 'Healthcare District' to be known as Northern Inyo Healthcare District

Now Therefore Be It Resolved that Northern Inyo County Local Hospital District be renamed 'Northern Inyo Healthcare District'

Be It Further Resolved that the Board of Directors now instruct the Chief Officers of Northern Inyo Hospital to take any and all necessary steps to change the name on legal documents and any other necessary recordings from Northern Inyo County Local Hospital District to Northern Inyo Healthcare District.

This Resolution is adopted February 17, 2016 by vote of the Board of Directors.

Denise M. Hayden

Denise Hayden, District Board President

M.C. Hubbard

M.C. Hubbard, District Board Secretary

California State Treasurer's Office
Local Agency Investment Fund (LAIF)

Authorization for Transfer of Funds

Effective Date	Agency Name	LAIF Account #
8/16/2017	Northern Inyo Healthcare District	20-14-002

Agency's LAIF Resolution # _____ or Resolution Date 8/16/2017

ONLY the following individuals whose names appear in the table below are hereby authorized to order the deposit or withdrawal of funds in LAIF. ***This authorization REPLACES AND SUPERCEDES all prior authorizations on file with LAIF for the transfer of funds.***

Name	Title
Kevin Flanigan, MD	Chief Executive Officer
Kristina Gritsutenko	Chief Financial Officer

Two authorized signatures required. Each of the undersigned certifies that he/she is authorized to execute this form under the agency's resolution, and that the information contained herein is true and correct.

Signature	Signature
Print Name	Print Name
Title	Title
Telephone	Telephone

Please provide email address to receive LAIF notifications.

Name	Email
Kevin Flanigan, MD	kevin.flanigan@nih.org
Kristina Grisutenko	kristina.grisutenko@nih.org

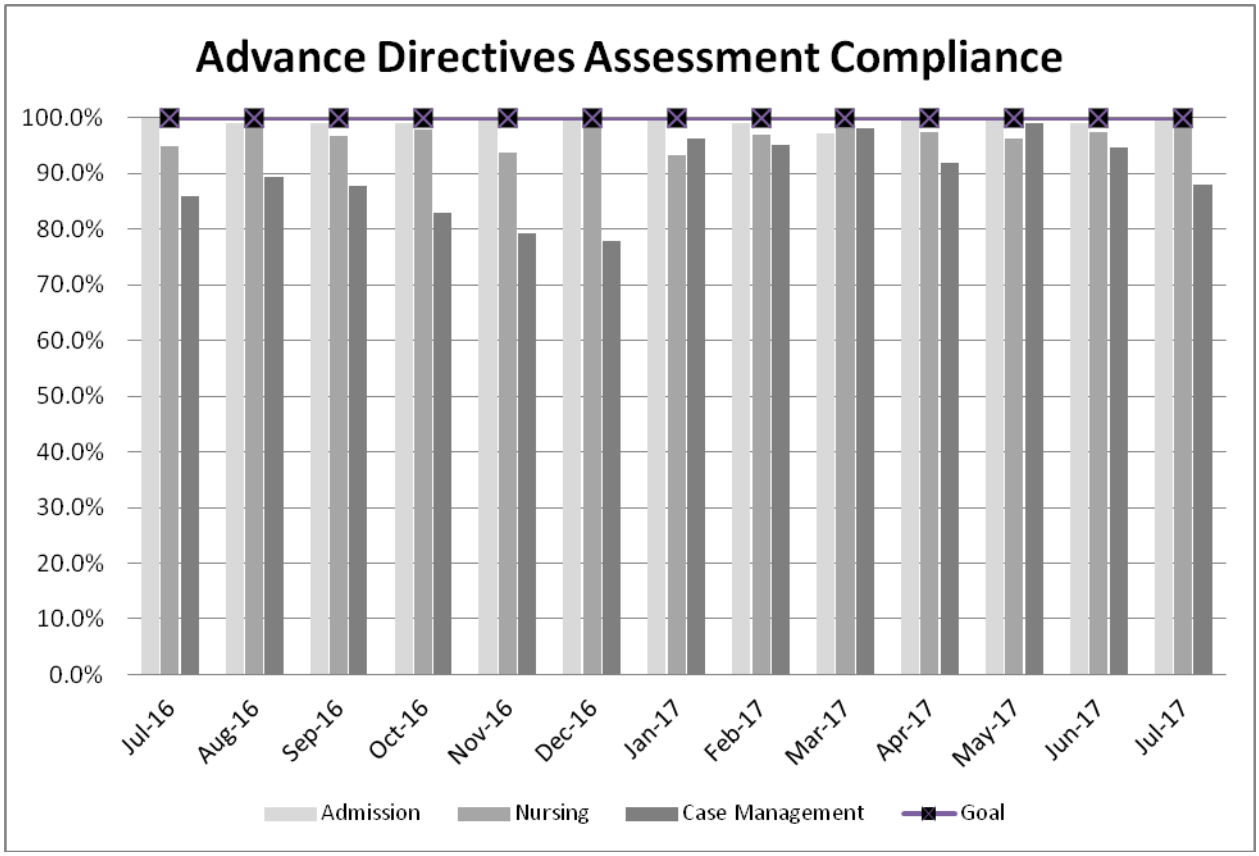
Mail completed form to: **State Treasurer's Office**
Local Agency Investment Fund
P.O. Box 942809
Sacramento, CA 94209-0001

STO-LAIF-4008
Revised 10/2016

2013 CMS Validation Survey Monitoring-August 2017

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

    a. Advance Directives Monitoring.

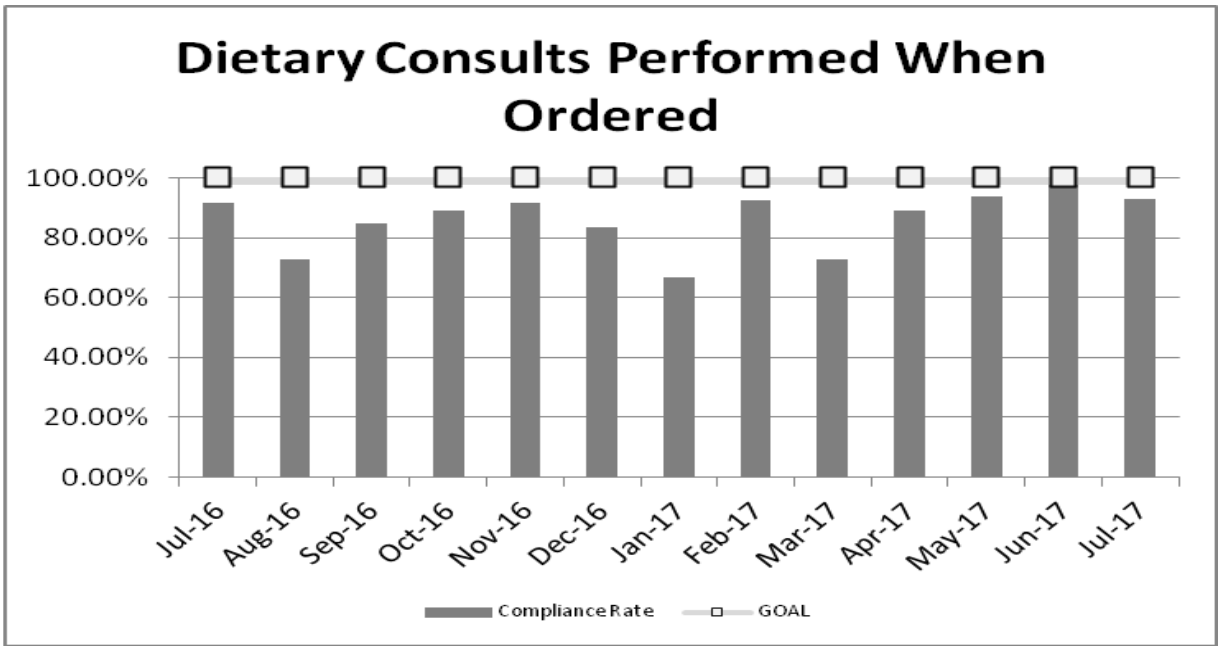


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

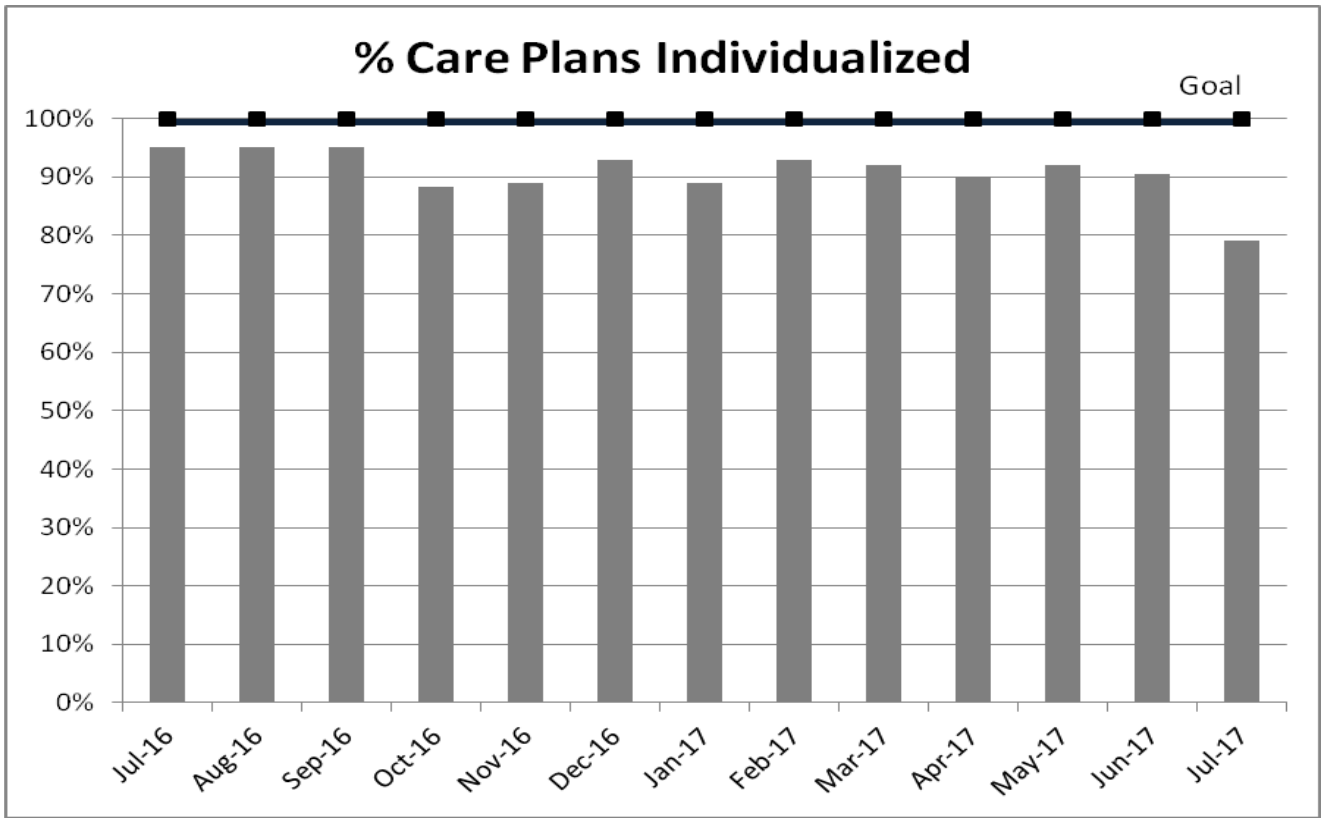
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

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

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

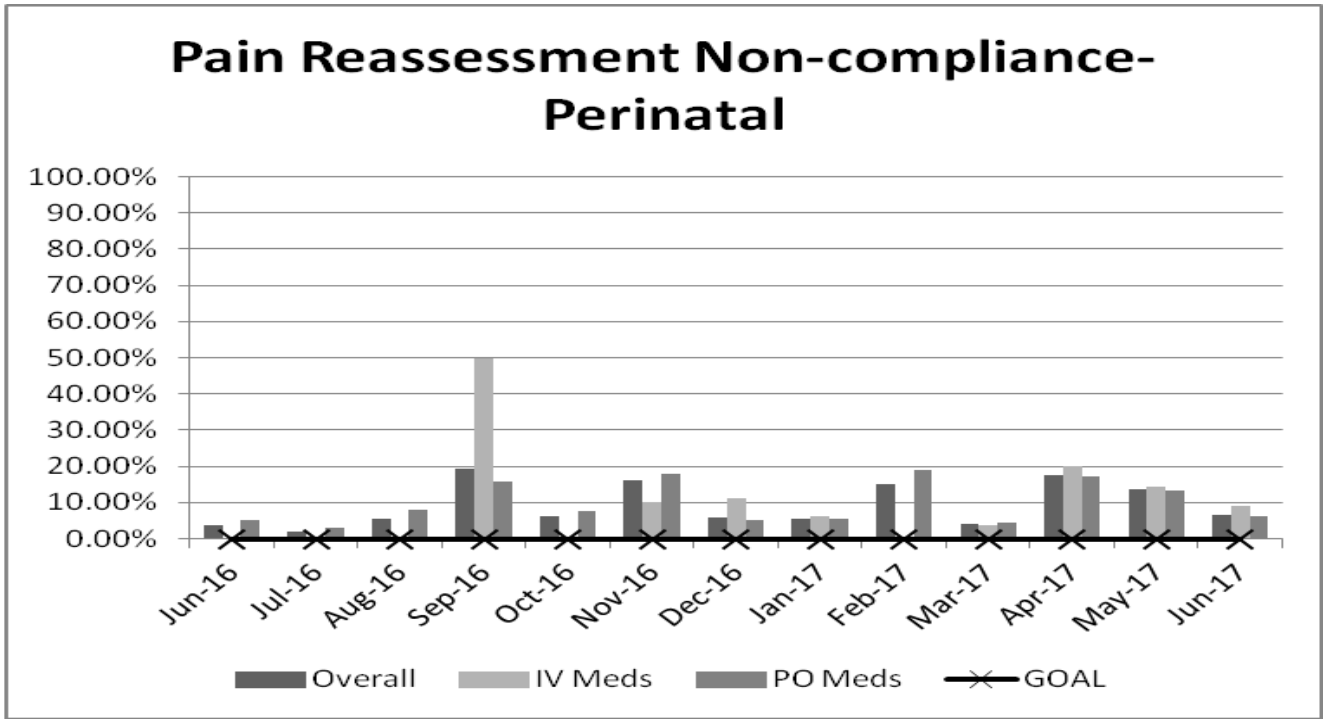


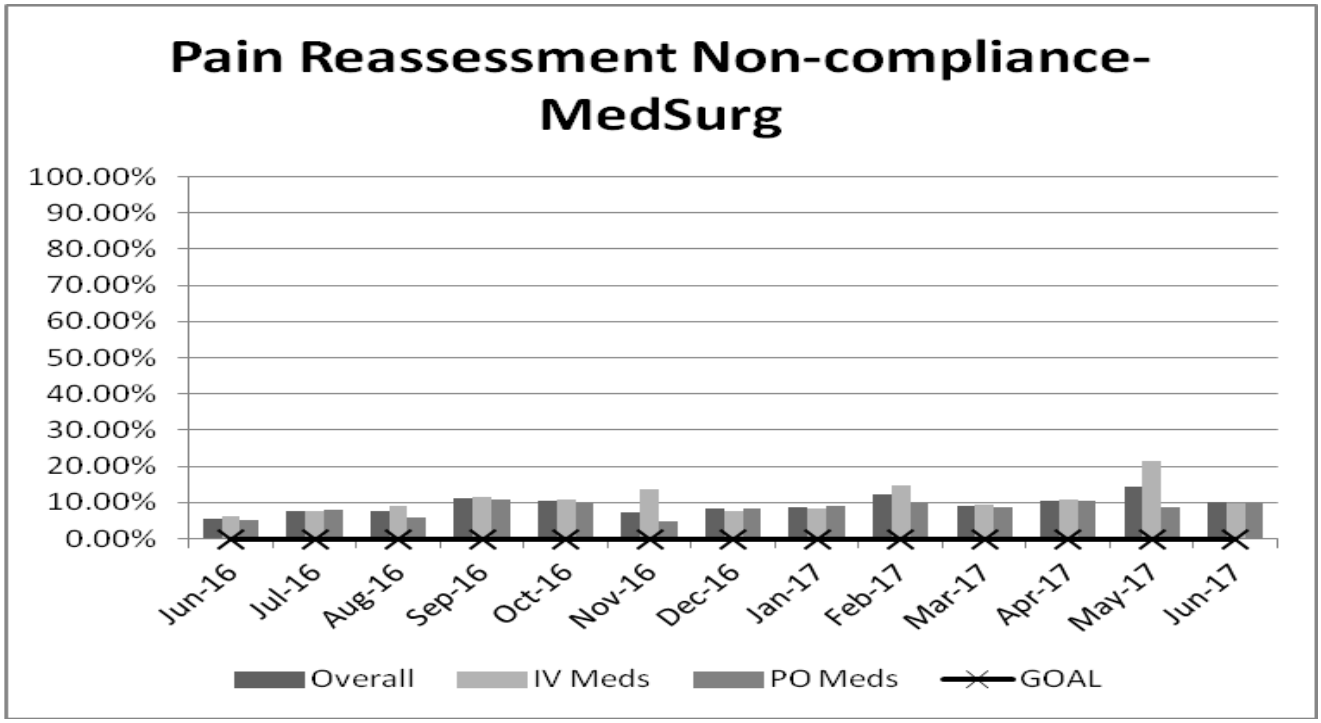
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

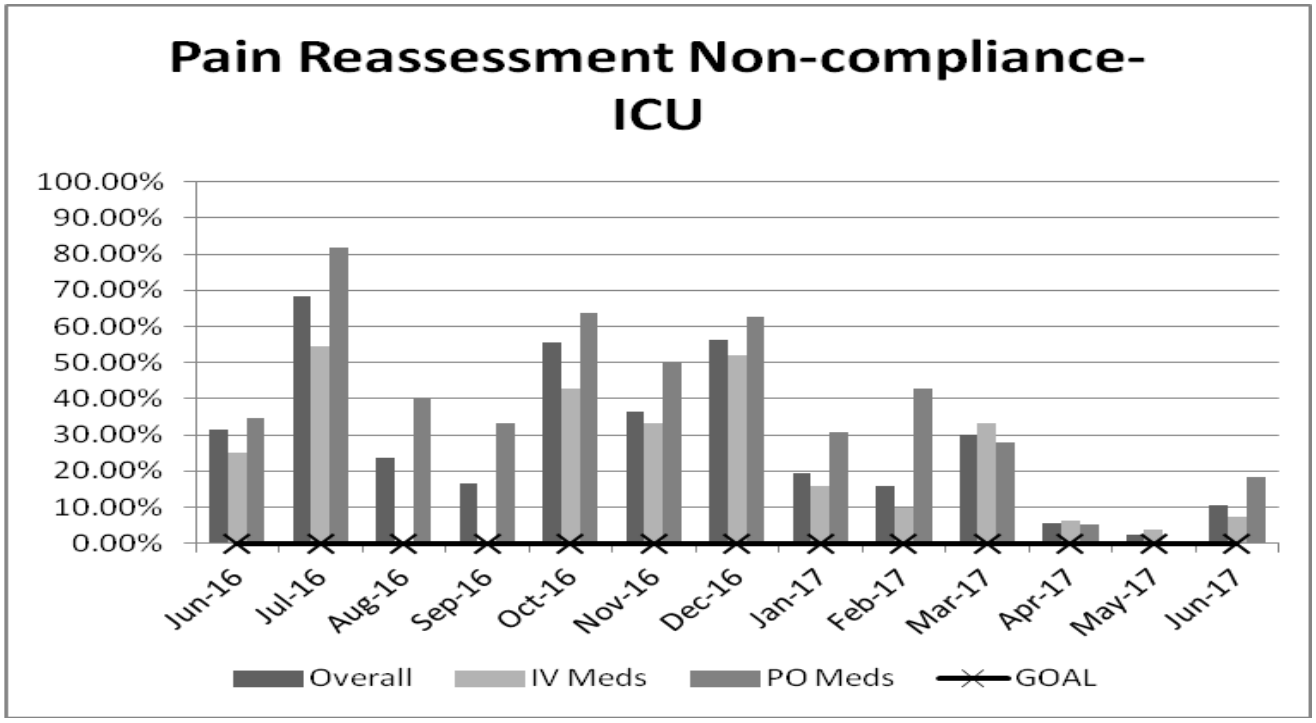


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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







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

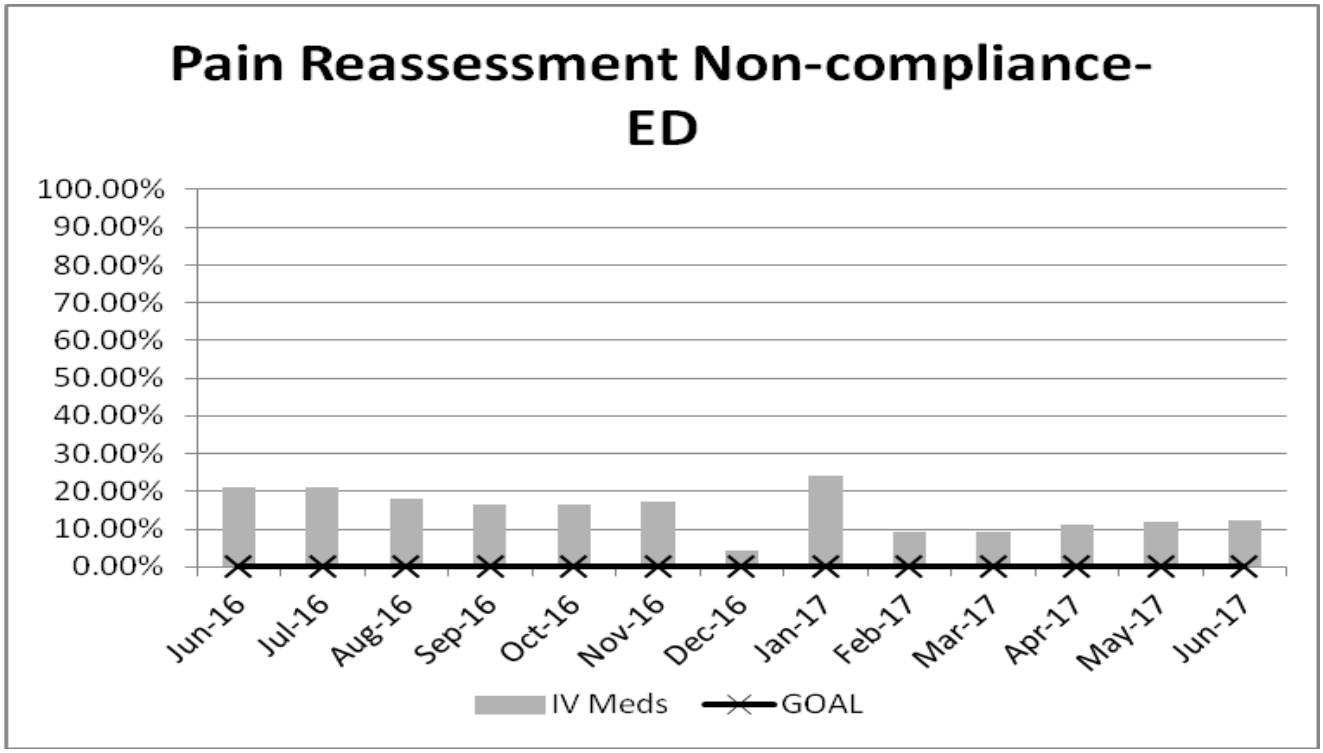


Table 6. Restraint chart monitoring for legal orders.

	Dec 2016	***Jan 2017***	***Feb 2017***	***March 2017***	***April 2017****	***May 2017***	***June 2017***	***July 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	2/2 (100%)	2/2 (100%	1/1 (100%)	1/1 (100%)		2/2 (100%)	2/2 (100%)	3/3 (100%)	100%
Physician signed order within 24 hours	2/2 (100%)	½ (50%)	1/1 (100%)	0/1 (0%)		2/2 (100%)	2/2 (100%)	3/3 (100%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	2/2 (100%)	0/2 (0%)	1/1 (100%)	0/1 (0%)		2/2 (100%)	1/2 (50%)	3/3 (100%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	2/2 (100%)	3/9 (33%)	0/1 (0%)	0/1 (0%)		0/1 (0%)	3/3 (100%)	2/5 (40%)	100%
Orders are for 24 hours	4/4 (100%)	11/11 (100%)	2/2 (100%)	2/2 (100%)		3/3 (100%)	5/5 (100%)	8/8 (100%)	100%
Is this a PRN (as needed) Order	0/4 (0%)	0/11 (0%)	0/2 (0%)	0/2 (0%)		0/3 (0%)	0/5 (0%)	0/8 (0%)	0%

*No restraint orders for this time interval

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

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	873,492	862,603	10,889	9,238,405	10,494,945	(1,256,540)
Ancillary	2,396,323	2,849,476	(453,153)	29,795,266	34,668,585	(4,873,319)
Total Inpatient Service Revenue	3,269,814	3,712,079	(442,265)	39,033,671	45,163,530	(6,129,859)
Outpatient Service Revenue	7,205,534	7,252,844	(47,310)	90,493,534	88,243,011	2,250,523
Gross Patient Service Revenue	**10,475,348**	**10,964,923**	**(489,575)**	**129,527,205**	**133,406,541**	**(3,879,336)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	228,282	169,290	58,992	2,603,784	2,059,696	544,088
Contractual Adjustments	3,783,766	4,326,329	(542,563)	55,665,210	52,636,994	3,028,216
***Prior Period Adjustments**	**59,104**	-	59,104	(5,880,211)	-	(5,880,211)
Total Deductions from Patient Service Revenue	**4,071,151**	**4,495,619**	**(424,468)**	**52,388,783**	**54,696,690**	**(2,307,907)**
Net Patient Service Revenue	**6,404,197**	**6,469,304**	**(65,107)**	**77,138,421**	**78,709,851**	**(1,571,430)**
Other revenue	(79,036)	52,083	(131,119)	452,015	633,683	(181,668)
Total Other Revenue	**(79,036)**	**52,083**	**(131,119)**	**452,015**	**633,683**	**(181,668)**
Expenses:						
Salaries and Wages	2,013,998	2,118,240	(104,242)	23,374,754	25,771,935	(2,397,181)
Employee Benefits	1,475,374	1,377,986	97,388	16,691,293	16,765,355	(74,062)
Professional Fees	985,253	695,784	289,469	10,717,094	8,465,390	2,251,704
Supplies	1,020,275	550,295	469,980	7,746,126	6,695,257	1,050,869
Purchased Services	501,095	331,158	169,937	3,490,328	4,029,062	(538,734)
Depreciation	452,081	414,340	37,741	5,028,944	5,041,141	(12,197)
Bad Debts	212,841	192,100	20,741	2,752,766	2,337,214	415,552
Other Expense	421,159	314,449	106,710	4,106,680	3,825,813	280,867
Total Expenses	**7,082,075**	**5,994,352**	**1,087,723**	**73,907,986**	**72,931,167**	**976,819**
Operating Income (Loss)	**(756,914)**	**527,035**	**(1,283,949)**	**3,682,451**	**6,412,367**	**(2,729,916)**
Other Income:						
District Tax Receipts	48,644	47,978	666	583,727	583,730	(3)
Tax Revenue for Debt	578,951	70,719	508,232	2,239,071	860,412	1,378,659
Partnership Investment Income		-	-		-	-
***Grants and Other Contributions Unrestricted**		8,219	(8,219)	117,148	99,998	17,150
Interest Income	114,701	17,965	96,736	313,502	218,568	94,934
Interest Expense	(78,339)	(237,024)	158,685	(2,989,223)	(2,883,794)	(105,429)
Other Non-Operating Income	661	2,137	(1,476)	73,853	25,998	47,855
Net Medical Office Activity	(376,149)	(340,775)	(35,374)	(4,027,278)	(4,146,092)	118,814
340B Net Activity	1,810	11,917	(10,107)	(26,454)	144,996	(171,450)
Non-Operating Income/Loss	**290,278**	**(418,864)**	**709,142**	**(3,715,654)**	**(5,096,184)**	**1,380,530**
Net Income/Loss	**(466,636)**	**108,171**	**(574,807)**	**(33,204)**	**1,316,183**	**(1,349,387)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

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

Year to date for the month ending June 30, 2017

	-630 or	-15%	less IP days than in the prior fiscal year
$	(6,129,859) or	-13.57%	under budget in Total IP Revenue and
$	2,250,523 or	2.6%	over budget in OP Revenue resulting in
$	(3,879,336) or	-2.9%	under budget in gross patient revenue &
$	(1,571,430) or	-2.0%	under budget in net patient revenue

Year-to-date Net Revenue was		$	77,138,421
Total Operating Expenses were:		$	73,907,986
			for the fiscal year to date
$	976,819 or	1.3%	over budget. Salaries and Wages were
$	(2,397,181) or	-9.3%	under budget and Employee Benefits
$	(74,062) or	-0.4%	Under budget due to Defined Benefit Pension Accrual Correction
		71%	Employee Benefits Percentage of Wages

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

$	2,251,704 or	26.6%	Professional Fees continue to run over budget due to contracted or registry staff and changes to specific physician contracts
$	1,050,869 or	15.7%	Supplies running over budget primarily in Surgery and Patient Supplies related to implentation of DaVinci Robotics
$	415,552 or	17.8%	Bad Debt Expense running over budget
$	280,867 or	7.3%	Other Expenses are over budget due to lease on DaVinci surgical equipment

Other Information:

$	3,682,451		Operating Income, less
$	(3,715,654)		loss in non-operating activities created a net Loss of;
$	(33,204)	$ (1,349,387)	Under budget.
		40.45%	Contractual Percentages for Year and
		41.00%	Budgeted Contractual Percentages including

$ 5,880,211 in prior year cost report settlement activity for Medicare & Medi-Cal including Intergovernment Transfer Funds (IGT) from Managed Care Medi-Cal & Contractuals include the Final settlement for Medicare fiscal year 2015 cost report. We evaluated the 3rd party liabilities for all other Medicare and Medi-Cal open Cost Reports based on current available information resulting in a change in the Prior Year Activities for contractual allowances. Finally, there was an adjustment due to correction for $495K from Grants to Contractual activity for PRIME IGT receipt from October 2016 bringing the total PRIME IGT receipts for the fiscal year to $1,985,000.

Non-Operating actives included:

$	(4,027,278) loss	$ (118,814)	under budget in Medical Office Activities
$	(26,454)	$ (171,450)	under budget in 340B Pharmacy Activity

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending June 30, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	3,246,865	2,197,973	1,048,892
Short-Term Investments	12,825,298	12,905,428	(80,130)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	779,134	779,134	-
Patient Receivable	59,607,558	61,464,299	(1,856,742)
Less: Allowances	(46,489,507)	(46,630,030)	140,523
Other Receivables	945,784	596,521	349,264
Inventories	3,461,829	3,761,437	(299,608)
Prepaid Expenses	1,355,284	1,319,086	36,198
Total Current Assets	**35,732,245**	**36,393,847**	**(661,603)**
Internally Designated for Capital Acquisitions	1,124,992	1,124,946	46
Special Purpose Assets	1,555,094	1,555,052	42
Limited Use Asset; Defined Contribution Pension	424,377	344,247	80,130
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Limited Use Asset Defined Benefit Plan 003	-	-	-
Revenue Bonds Held by a Trustee	2,720,239	3,035,044	(314,805)
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,969,227**	**20,203,813**	**(234,587)**
Long Term Investments	1,750,000	1,750,000	-
			-
Property & equipment, net Accumulated Depreciation	79,787,383	80,395,086	(607,703)
Unamortized Bond Costs	-	-	-
Total Assets	**137,238,854**	**138,742,747**	**(1,503,892)**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending June 30, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,048,310	39,404	2,008,906
Accounts Payable	1,446,183	1,780,115	(333,931)
Accrued Salaries, Wages & Benefits	4,265,677	5,116,597	(850,920)
Accrued Interest and Sales Tax	181,121	682,913	(501,791)
Deferred Income	52,765	48,644	4,120
Due to 3rd Party Payors	1,122,302	1,122,302	-
Due to Specific Purpose Funds	-	(705,162)	705,162
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**10,543,879**	**9,512,333**	**1,031,546**
Long Term Debt, Net of Current Maturities	43,931,947	46,012,756	(2,080,809)
Bond Premium	621,454	720,084	(98,630)
Accreted Interest	10,867,094	10,756,545	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**88,912,963**	**90,981,854**	**(2,068,891)**
Net Assets			
Unrestricted Net Assets less Income Clearing	36,260,123	35,377,326	882,797
Temporarily Restricted	1,555,094	1,555,052	42
Net Income (Income Clearing)	(33,204)	433,432	(466,636)
Total Net Assets	**37,782,013**	**37,365,809**	**416,203**
Total Liabilities and Net Assets	**137,238,854**	**137,859,996**	**(621,142)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending June 30, 2017

	Month to Date	FYE 2017 Year-to-Date	FYE 2016 Year-to-Date	Variance from PY	Variance %
Licensed Beds	25	25	25		
Total Patient Days with NB	331	3,539	4,169	(630)	-15%
Total Patient Days without NB	297	3,195	3,792	(597)	-16%
Swing Bed Days	33	393	719	(326)	-45%
Discharges without NB	108	1,091	1,131	(40)	-4%
Swing Discharges	7	65	110	(45)	-41%
Days in Month	30	365	366		
Occupancy without NB	9.90	8.75	10.36	(1.6)	-16%
Average Stay (days) without NB	2.75	2.93	3.35	(0.4)	-13%
Average LOS without NB/Swing	2.61	2.73	3.01	(0.3)	-9%
Hours of Observation (OSHPD)	817	9,212	6,948	2,264	33%
Observation Adj Days	34	384	290	94	33%
ER Visits All Visits	859	9,750	9,978	(228)	-2%
RHC Visits (OSHPD)	3,116	30,031	27,302	2,729	10%
Outpatient Visits (OSHPD)	3,245	38,829	38,454	375	1%
IP Surgeries (OSHPD)	23	274	297	(23)	-8%
OP Surgery (OSHPD)	111	1,239	1,232	7	1%
Worked FTE's	336.00	333.00	319.00	14	4%
Paid FTE's	384.00	373.00	361.00	12	3%
Hours Worked to Hours Paid%	87.5%	89.3%	88.4%	0.9%	1%
Payor %					
Medicare		41%	40%	1%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		33%	35%	-2%	
Indigent (Charity Care)		1.2%	0.3%	0.9%	
All Other		2%	2%	0%	
Total		100%	100%		

Northern Inyo Healthcare District

Preliminary Financial Indicators as of June 30, 2017

	Target	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16
Current Ratio	>1.5-2.0	3.39	3.83	3.51	3.41	3.45	3.53	3.69	2.85	2.95	2.60	2.15	2.05	1.98
Quick Ratio	>1.33-1.5	2.84	3.23	2.96	2.88	2.90	2.93	2.92	2.46	2.41	2.20	1.83	1.74	1.71
Days Cash on Hand prior method	>75	154.70	160.60	159.55	160.80	157.10	151.40	140.37	160.86	145.43	157.98	168.91	162.64	161.90
Days Cash on Hand Short Term Sources	>75	79.37	75.71	76.12	77.66	79.99	71.85	62.90	85.97	67.02	77.60	86.56	91.08	96.57
Debt Service Coverage	>1.5-2.0	1.81	1.96	1.91	2.07	2.23	2.17	2.13	2.46	2.30	2.80	3.18	2.03	1.95
Operating Margin		4.71	6.18	6.06	6.01	6.83	6.30	5.59	7.48	6.43	8.37			
Outpatient Revenue % of Total Revenue		69.86	69.96	69.76	69.43	69.11	69.10	69.28	68.11	67.48	67.03			
Cash flow (CF) margin (EBIDA to revenue)		2.48	2.84	2.59	3.41	4.27	3.94	3.71	5.43	4.53	7.01			
Days in Patient Accounts Receivable	<60 Days	78.90	89.00	86.00	85.10	76.70	80.80	77.70	75.60	75.00	77.80	78.50	73.10	63.20

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

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

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

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

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

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

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

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

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of June 30, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	30-Jun-17	01-Jul-17	Local Agency Investment Fund	Northern Inyo Hospital	0.98%		12,575,297.73
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				SHORT TERM INVESTMENTS		$	12,825,297.73
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				LONG TERM INVESTMENTS		$	1,750,000.00
				Total Investments		$	14,575,297.73

Funds for Defined Contribution Plan held at Local Agency Investment Fund

1	30-Jun-17	01-Jul-17	LAIF Defined Cont Plan	Northern Inyo Hospital	0.98%		424,377.00
				LAIF PENSION INVESTMENTS		$	424,377.00
							14,999,674.73

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances

for period ending June 30, 2017

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,268	$ 1,098,222	46
Equipment Fund Savings Account	$ 26,725	$ 26,724	1
Total Board Designated Funds:	**$ 1,124,992**	**$ 1,124,946**	**$ 46**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,421,952	$ 1,421,924	$ 29
Nursing Scholarship Savings Account	$ 33,037	$ 33,036	$ 1
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,028	$ 100,016	$ 12
Total Specific Purpose Funds:	**$ 1,555,093**	**$ 1,555,052**	**$ 42**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,680,086**	**$ 2,679,998**	**$ 88**

CALL TO ORDER	The meeting was called to order at 5:33 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer
ALSO PRESENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer Richard Meredick MD, Chief of Staff Kelli Huntsinger, Chief Operating Officer Kristina Gritsutenko, Chief Financial Officer Carrie Petersen, Chief Accounting Officer John Tremble, Fiscal Services Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Sandy Blumberg, Executive Assistant
ABSENT	Phil Hartz, Member At Large
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott asked if any members of the public wished to speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. No comments were heard.
NEW BUSINESS	
WORKER HOUSING POLICY AND PROCEDURE	Chief Executive Officer (CEO) Kevin S. Flanigan, MD, MBA called attention to a proposed Hospital Wide Policy and Procedure titled *Worker Housing Policy,* which specifies the circumstances and conditions under which the District will provide housing to employees and other workers. It was moved by John Ungersma, MD, seconded by M.C. Hubbard, and unanimously passed to approve the Hospital Wide Policy and Procedure titled *Worker Housing Policy* as presented.
PURCHASING AND SIGNATURE AUTHORITY POLICY AND PROCEDURE	Doctor Flanigan also called attention to a revised Hospital Wide Policy and Procedure titled *Purchasing and Signature Authority* which increases the existing purchasing authorization levels of Northern Inyo Healthcare District (NIHD) managers, directors, and chiefs. It was moved by Ms. Hubbard, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the revised Hospital Wide *Purchasing and Signature Authority* Policy and Procedure as presented.
POLICY AND PROCEDURE ANNUAL APPROVALS	Mr. Watercott called attention to a list of Hospital Wide Policies and Procedures presented for annual approval, as listed on Attachment A to the agenda for this meeting. It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve all Policies and Procedures listed on Attachment A to the agenda as presented.

APPOINTMENT OF NIHD FOUNDATION BOARD MEMBER

Doctor Flanigan requested approval of the appointment of Ms. Patricia Barton to the NIHD Foundation Board, per the recommendation of existing Foundation Board members and the Foundation Executive Director. It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma and unanimously passed to appoint Ms. Patricia Barton to the NIHD Foundation Board as recommended.

SUPPLEMENTAL INFORMATION TECHNOLOGY BUDGET

Doctor Flanigan called attention to a supplemental Information Technology budget which provides two options for upgrading OBTV documentation and interfaces for the Perinatal Department. Following review of the information provided it was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve the supplemental Information Technology budget allowing for the purchase of a General Electric OBTV upgrade product, as recommended by Nursing management and Hospital management.

NON CORPORATE BANKING RESOLUTIONS

Chief Accounting Officer Carrie Petersen called attention to Non-Corporate Banking Resolutions with Financial Northeastern Corporation, and Multi-Bank Securities, Inc., which will update District banking authorizations to identify Kevin S. Flanigan, MD, MBA, Chief Executive Officer, and Kristina Gritsutenko, Chief Financial Officer as the investment officers for the District. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve both Non-Corporate Banking Resolutions as presented.

CONSENT AGENDA

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

- Approval of minutes of the June 21, 2017 regular meeting
- Approval of minutes of the June 29, 2017 special meeting
- 2013 CMS Validation Survey Monitoring, July 2017
- Financial and Statistical Reports for the period ending May 31, 2017

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve all consent agenda items as presented.

PATIENT EXPERIENCE COMMITTEE REPORT

Chief Nursing Officer Tracy Aspel RN provided a Patient Experience Committee Report which included an overview of improvements made to patient services and access to care at the NIHD Rural Health Clinic (RHC). Ms. Aspel also requested that improvements to the NIHD Patient Portal be removed from the District's Strategic Plan for the current year, due to the fact that grant funding for that project is not available and future implementation of the Athena Health electronic medical record will include improvements to the Patient Portal. It was moved by Ms. Kilpatrick, seconded by Dr. Ungersma, and unanimously passed to remove improvements to the NIHD Patient Portal from this year's Strategic Plan.

WORKFORCE EXPERIENCE COMMITTEE REPORT

Chief Human Resources Officer Evelyn Campos Diaz provided a Workforce Experience Committee report which outlined progress made toward improving the NIHD workforce experience in the following areas:

- Employee engagement and empowerment
- Implementation of leadership trainings for NIHD managers
- Development of HR resources and tools
- Creation of opportunities for employee work/life balance
- Implementation of efforts to ensure a safe and secure workplace for District staff, visitors, and patients.

CHIEF OF STAFF REPORT

POLICIES, PROCEDURES, PROTOCOLS, ORDER SETS

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

- *High Alert Medications: Preparation, Dispensing, Storage*
- *Establishing a New Privilege or New Service (with worksheet)*
- *Endovaginal Ultrasound Probe Storage, Transportation, and Disinfection*
- *Glutaraldehyde Use Station GUS – STATION HIGH-LEVEL DISINFECTION DEVICE*

It was moved by Doctor Ungersma, seconded by Ms, Kilpatrick, and unanimously passed to approve all Policies, Procedures, Protocols, and Order Sets as presented.

MEDICAL STAFF OFFICERS AND SERVICE CHIEFS

Doctor Meredick also called attention to the proposed slate of Medical Staff Officers and Service Chiefs for the 2017/2018, year as follows:

- Chief of Staff: *Richard Meredick, MD*
- Vice Chief of Staff: *Allison Robinson, MD*
- Immediate Past Chief of Staff: *Joy Engblade, MD*
- Chief of Emergency Room Service: *Sierra Bourne, MD*
- Chief of Medicine/Intensive Care: *Nickoline Hathaway, MD*
- Chief of Obstetrics: *Martha Kim, MD*
- Chief of Pediatrics: *Charlotte Helvie, MD*
- Chief of Radiology: *Thomas McNamara, MD*
- Chief of Surgery: *L. Jeanine Arndal, MD*

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the proposed slate of Medical Staff Officers and Service Chiefs for the 2017/2018 year as presented.

MEDICAL STAFF PRIVILEGING

Doctor Meredick additionally stated that following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends privileging of Allied Health Professional Jennifer Figueroa, PA-C (Rural Health Clinic). It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve the privileging of Jennifer Figueroa, PA-C as requested.

BOARD MEMBER REPORTS	Mr. Watercott asked if any members of the Board of Directors wished to report on any items of interest. Doctor Ungersma reported the Association of California Healthcare Districts (ACHD) annual meeting will be held this September, and he encouraged his fellow Board members to attend.
ADJOURNMENT TO CLOSED SESSION	At 6:30 pm Mr. Watercott announced the meeting would adjourn to closed session to allow the Board of Directors to: A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*). B. Confer with legal counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation, 4 matters pending (*pursuant to Government Code section 54956.9*). C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*). D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
RETURN TO OPEN SESSION AND REPORT OF ATION TAKEN	At 7:33 pm the meeting returned to open session. Mr. Watercott reported that the Board has agreed to join the Inyo County Local Agency Formation Commission (LAFCO) in an appeal of the ruling in the Southern Mono Healthcare District litigation.
ADJOURNMENT	The meeting adjourned at 7:34 pm.

_____
Peter Watercott, President

Attest:

_____
M.C. Hubbard, Secretary

BOARD MEETING ATTENDANCE, BOARD TERM BEGINNING DECEMBER 2016

	PETE WATERCOTT ***President***	**J. UNGERSMA, MD** ***Vice President***	**M.C. HUBBARD** ***Secretary***	**MARY MAE KILPATRICK** ***Treasurer***	**PHIL HARTZ** ***Member at Large***
December 14, 2016	√	√	√	√	√
January 18, 2017	√	√	√	√	√
February 15, 2017	√	√	√	√	√
March 1, 2017 (Special)	√	√	√	√	*Absent*
March 15, 2017	√	√	√	√	√
April 19, 2019	√	√	√	√	√
May 5, 2017 (Special)	√	√	√	√	*Absent*
May 17, 2017	√	√	√	√	*Absent*
June 21, 2017	√	√	√	√	√
June 29, 2017 (Special)	√	√	√	√	*Absent*
July 19, 2017	√	√	√	√	*Absent*
August 16, 2017					
September 20, 2017					
October 18, 2017					
November 15, 2017					
December 20, 2017					

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Compliance Report
August 2017

1. Comprehensive Compliance Program review
    a. As of August 1, 2017, >70% of the individuals to whom the Compliance Program has been assigned have reviewed the program.
2. Breaches
    a. Calendar Year (CY) 2017 – (exhibit A)
        i. 38 alleged breaches of PHI (Personal Health Information) potentially affecting 59 patients have been investigated by the Compliance Office
        ii. 19 alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. 6 have had deficiencies assigned. When a deficiency is assigned, civil monetary penalties may be assessed.
            2. 8 case is still pending CDPH investigation.
3. Issues and Inquiries – (see exhibit B)
    a. CY 2017 – More than 100 requests for research and input on a wide variety of topics have been made to the Compliance Department
4. Conflicts of Interest questionnaires – (exhibit C)
5. CPRA Requests
    a. The Compliance office has prepared documents for 5 CPRA requests in CY 2017.
    b. This is a significant reduction in public records requests from the past several years.
6. Audits
    a. Employee Access Audits (exhibit D)- The Compliance Office manually completes access audits of patient information systems to ensure that employees access records only on a "need to know" and "minimum necessary" basis.
        i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
        ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.

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iii. Compliance performs between 400-500 audits monthly.
    1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.

b. Excluded Individuals and Entities audit – see attached report (exhibit E)with same title
    i. Complete review of entire vendor master in Paragon
    ii. Complete review of entire caregiver master in Paragon
    iii. Working with Accounting Dept., Infection Control, and Director of Materials Management to review and update appropriate policies and procedures to move to a fully compliant process for credentialing of vendors, individuals, and entities with whom NIHD conducts business.

c. Business Associates Agreements audit
    i. Contracts are currently under review to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement, as required by HIPAA laws.

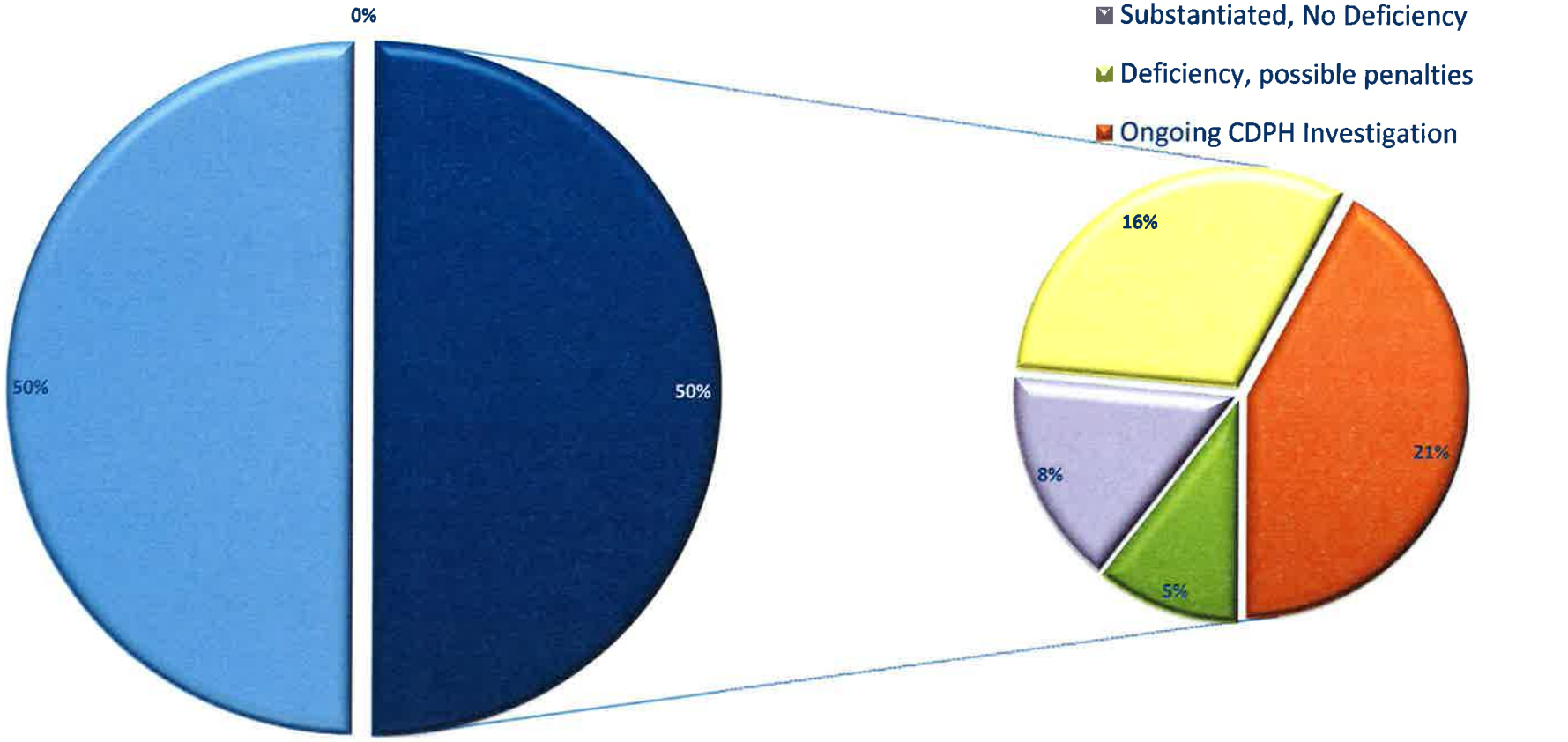
7. Projects

a. Signage
    i. History: There are approximately 600-700 documents that must be posted in different locations around the Hospital and District Clinic offices.
    ii. Signage project was approved in the capital budget.
        1. Property management is now working with the maintenance department to begin implementation.
        2. "New" hospital main lobby and the ER departments will be first to have new signage.

b. Compliance Auditing Software
    i. Will move auditing from a 100% manual process to a significantly automated process; provides near real-time auditing to better detect and prevent unauthorized access of PHI; improve effectiveness and efficiency;
    ii. Cost captured in FY18 Supplemental IT budget
    iii. Will be prioritized along with many IT projects for current FY

2017 Breach Outcomes

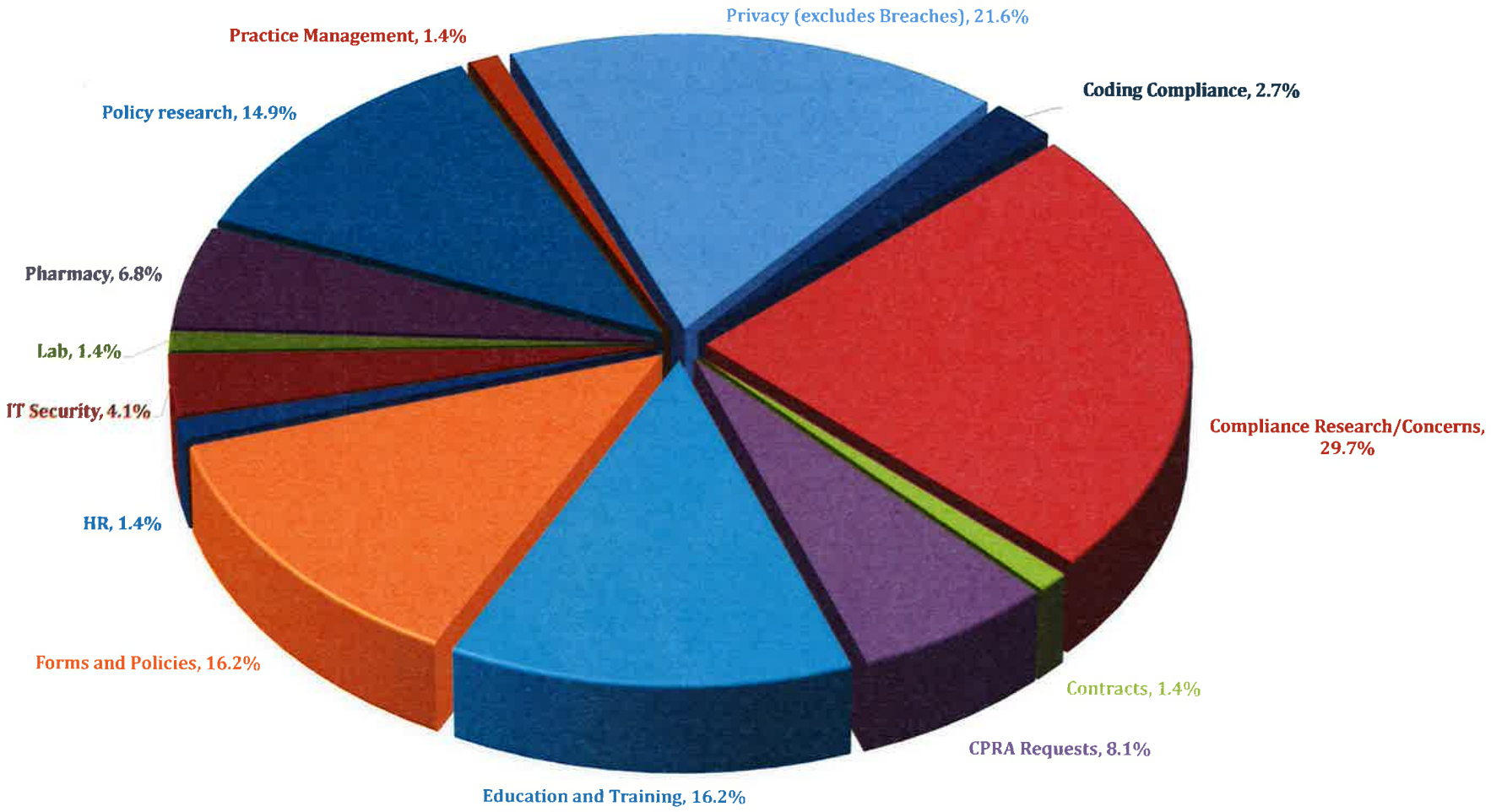
27 Breach investigations potentially affecting 37 patients



August 1, 2017

Exhibit A

REQUESTS FOR RESEARCH AND ASSISTANCE FROM THE COMPLIANCE DEPARTMENT



The Compliance Department has provided assistance and support to other departments for more than 97 requests in calendar year 2017. This chart demonstrates the general types of requests, inquiries, and concerns and are a reflection of staff requests.

Exhibit B

Exhibit C

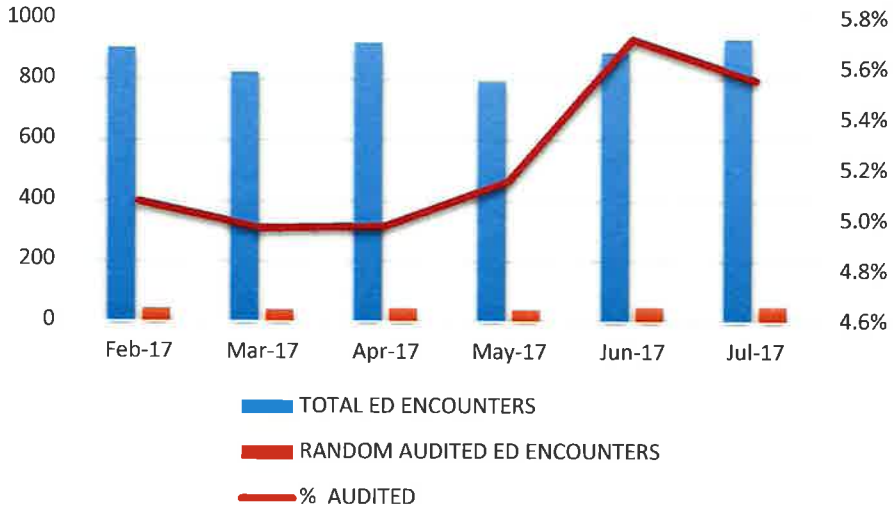
Compliance Report - Conflicts of Interest		Target = 100%
		CY 2017
Number of Forms received (new employees, annual, role changes)	525	
Conflicts of Interest Forms Reviewed	525	100.0%
COI with no conflicts	398	
COI with Category A conflict	86	
COI with Category B conflict	41	
COI with Category C conflict	0	
Non-Disclosure Agreements/ Management Plans requested	41	
Non-Disclosure Agreements/ Management Plans received	35	85.4%

Definitions

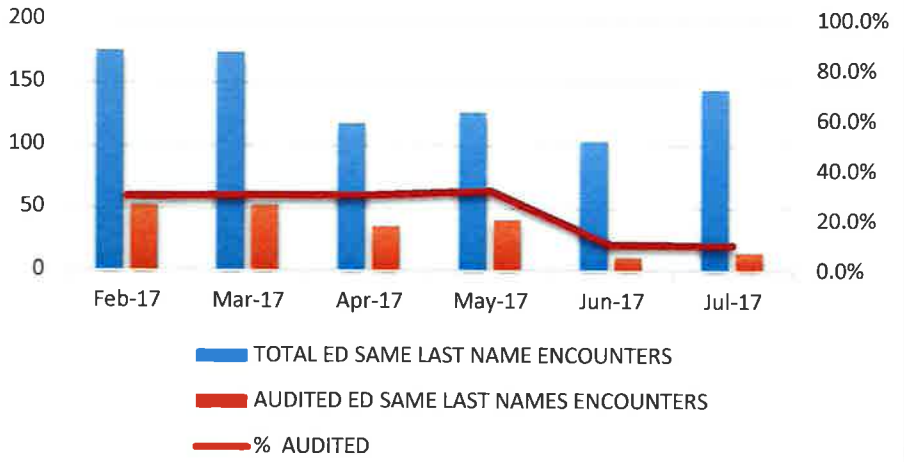
Category A conflict:	Not significant and generally permissible activities.
Category B conflict:	Potential or perceived conflict of interest. Activities may be permitted after Non-Disclosure Agreement and or Management Plan
Category C conflict:	Actual conflict of interest. Activities which represent actual conflicts of interest which may be permitted to go forward only with appropriate management plan to eliminate the conflict, safeguard against prejudice toward NIHD activities, and provide continuing oversight.

Emergency Room Encounters

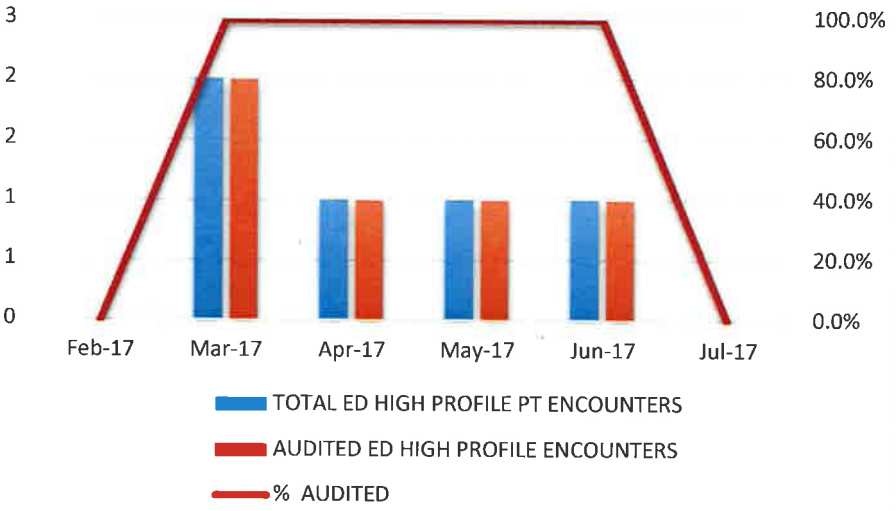
Random ED Encounter Audits



ED Patient with the same last name as an employee



ED High profile individuals



Employee as ED patient

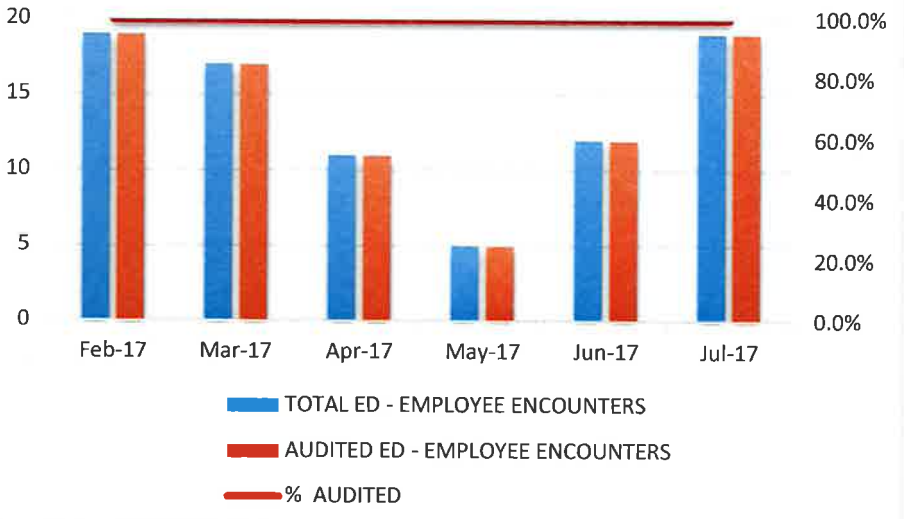
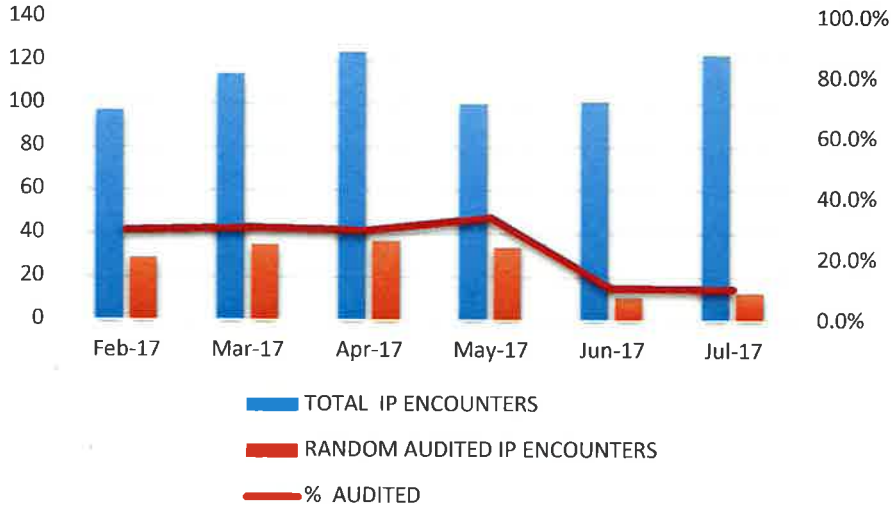


Exhibit D

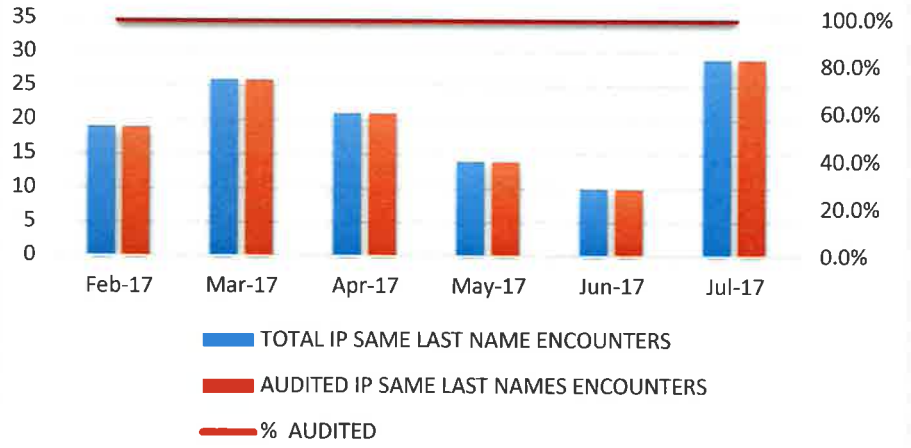
Employee EHR Access Audits

Inpatient Encounters

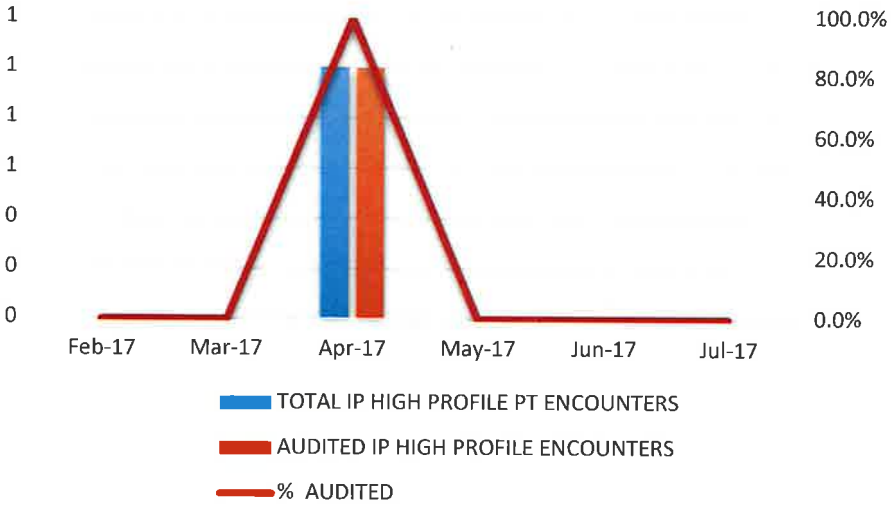
Random IP encounter Audits



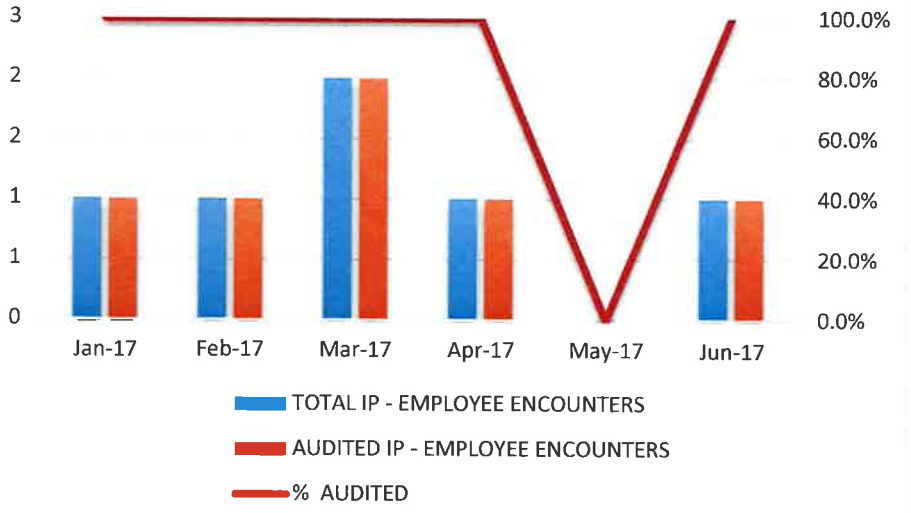
Inpatient with the same last name as an employee



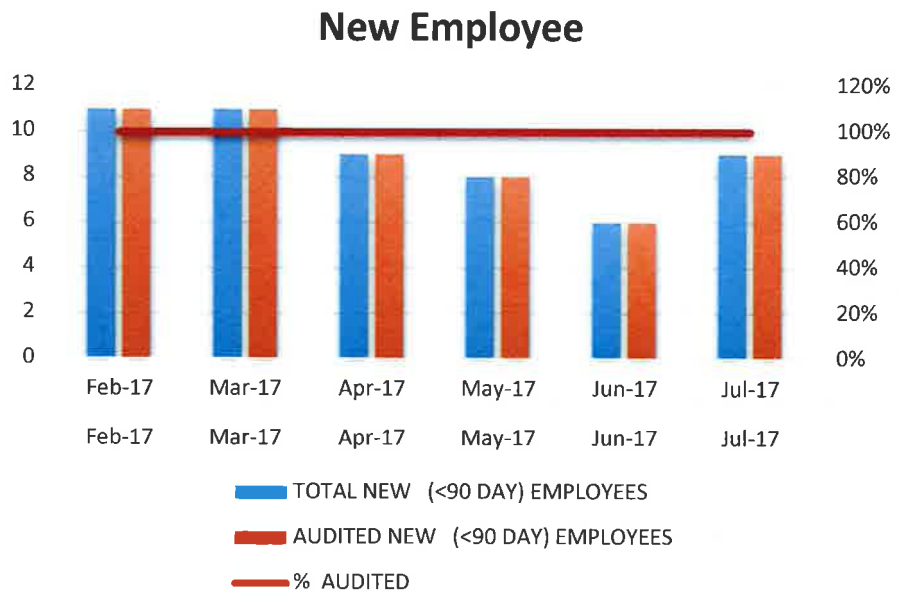
High Profile

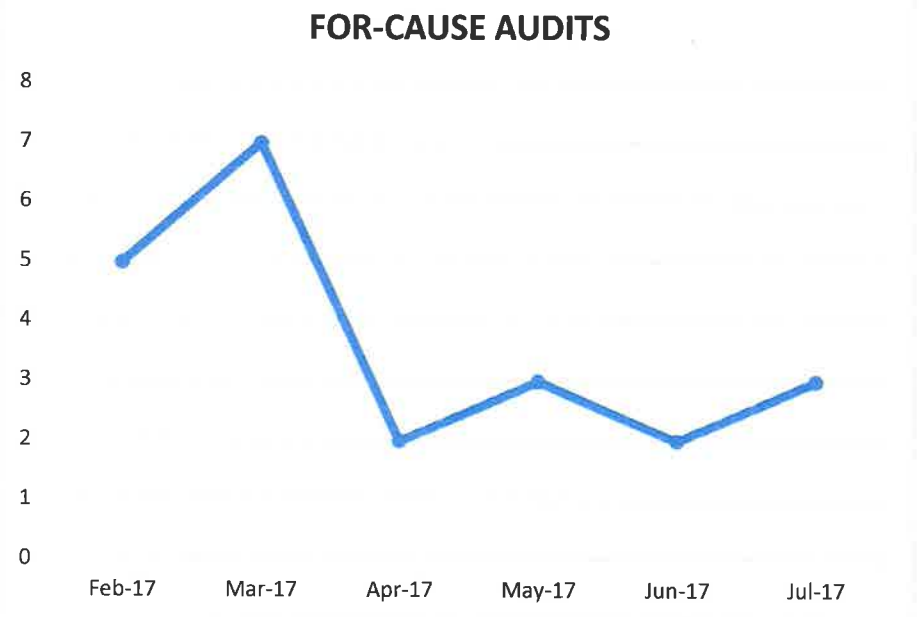


Employees

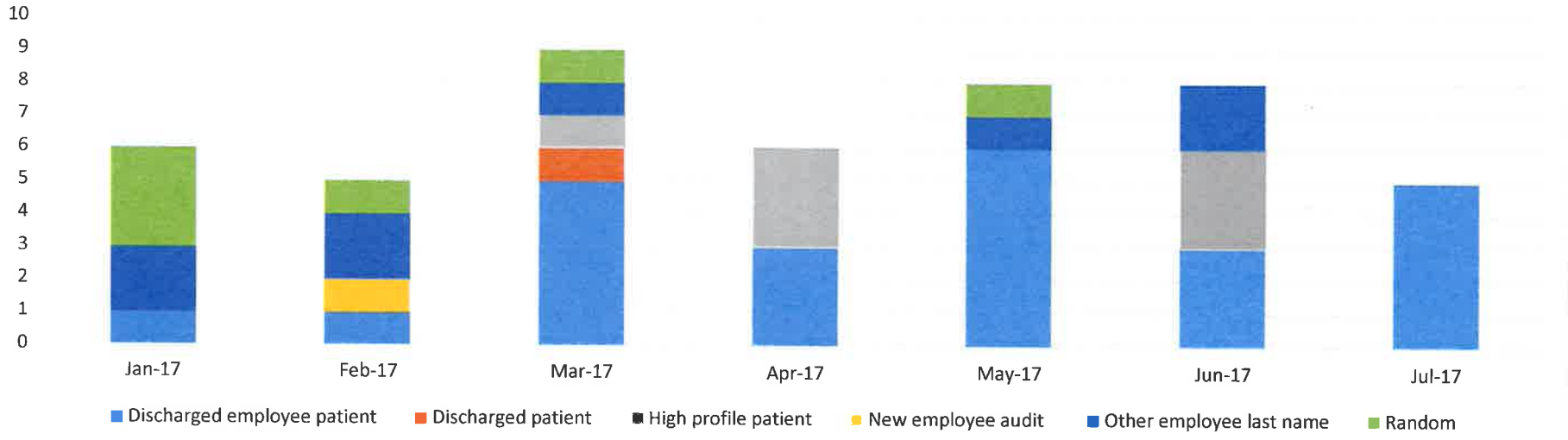


Employee EHR Access Audits





"FLAGS" - Audits requiring further investigation



Employee EHR Access Audits

"FLAGS" Outcomes

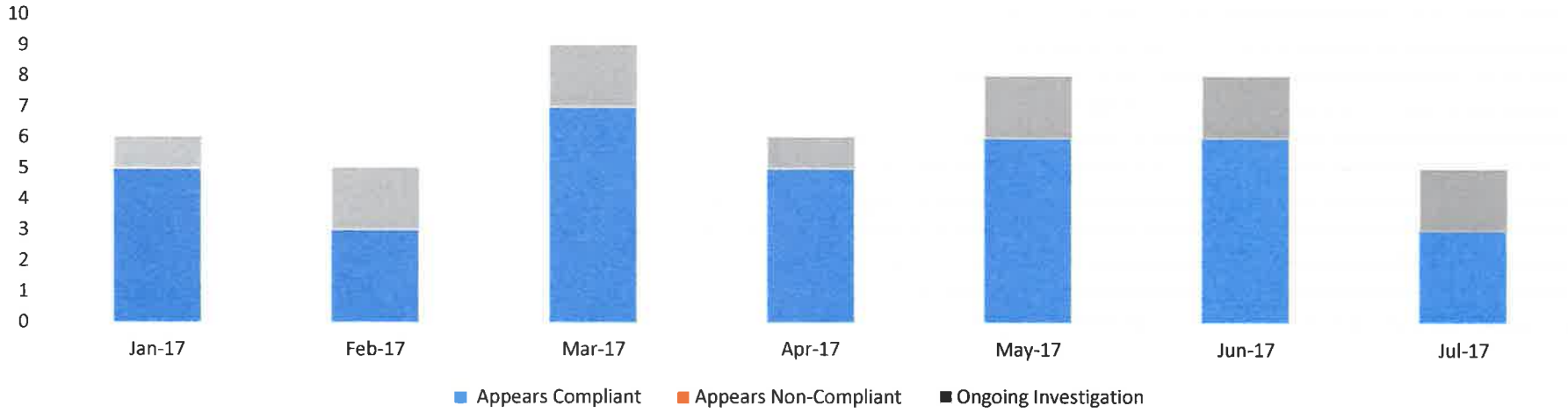


Exhibit E

Excluded Individuals and Entities Audit

Consistent with the District's Compliance Program directives to prevent and detect fraud, waste, and abuse, the Compliance Department has conducted a complete review of vendors, contractors, referring providers, and agents with which the District has conducted business in the last seven years. Conducting business with excluded individuals and entities can have serious consequences, up to and including exclusion from participation in Federal health programs.

Background information from the Department of Health and Human Services Exclusions webpage:

"Office of Inspector General (OIG) was established in the U.S. Department of Health and Human Services (Department) to identify and eliminate fraud, waste, and abuse in the Department's programs and to promote efficiency and economy in Departmental operations."

HHS OIG *"has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). Anyone who hires* (or bills government entities for services provided or referred by) *an individual or entity on the LEIE may be subject to civil monetary penalties (CMP)."*

"The effects of an exclusion are outlined in the Updated Special Advisory Bulletin on the Effect of Exclusions From Participation in Federal Health Programs, but the primary effect is that no payment will be provided for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This includes Medicare, Medicaid, and all other Federal plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan). For purposes of Office of Inspector General (OIG) exclusion, payment by a Federal health care program includes amounts based on a cost report, fee schedule, prospective payment system, capitated rate, or other payment methodology."

"To avoid CMP liability, health care entities need to routinely check the LEIE to ensure that new hires and current employees are not on the excluded list." (U.S. DHHS, OIG)

The Human Resources Department at NIHD has in place a process to verify all employees are screened for exclusion before hire, and annually, as recommended.

The Accounting Department has nearly 3000 vendors, agents, and entities with whom we have conducted business. The Hospital Information System has more than 4100 referring providers (physicians, nurse practitioners, physician's assistants, etc.) from whom we have accepted referrals for patient services. The processes for verifying that these vendors, agents, entities, and referring providers are not on the exclusion lists has not been as clearly defined.

The Compliance Department has verified that NIHD has not conducted business with individuals and entities on the Federal List of Excluded Individuals and Entities or the California Medi-Cal list of Suspended and Ineligible Providers List.

	Referring Providers		Vendors, Individuals, and Entities	
	Actual #	Percentage	Actual #	Percentage
Total # in NIHD Systems	4173		2997	
Reviewed for exclusion	4173	100.0%	2997	100.0%
Required additional investigation	33	0.8%	67	2.2%
Listed on one or more exclusion list	11	0.3%	4	0.1%
Excluded vendors/providers with whom NIHD has conducted business	0	0.0%	0	0.0%

The Compliance Department is now working with the Caregiver Master Team, Materials Management, and Accounting Departments to put in place policies and procedures to provide guidance for staff. This will ensure that individuals and entities are not on any exclusions lists prior to conducting business with them, and again annually, to ensure there has been no status change.

Reference: U.S. Department of Health and Human Services, Office of Inspector General
https://oig.hhs.gov/exclusions/background.asp

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Medical Staff Services

Department: Medical Staff Administration

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

			Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	
Indicator	Baseline	Goal	Q1	Q2	Q3	Q4	YTD
Service							
1. Customer satisfaction							
a. Average Credentialing TAT (from receipt of complete application)	1 day	<21 days	Not available	1 d	7 d	14 d	11 d
b. Average Privileging TAT (from receipt of complete application)	17 days	<60 days	Not available	17 d	19 d	30 d	25 d
c. Number of applications abandoned	1	<1 per Q	Not available	1	0	5	6
d. Percent on-time start	50%	100%	Not available	50%	100%	100%	92 %
Quality							
1. Application times							
a. Average time for any application materials to be returned	23 days	<14 days	Not available	23 d	25 d	29 d	28 d
b. Average time for complete application to be returned	64 days	<45 days	Not available	64 d	49 d	48 d	51 d
2. Credentialing/Privileging							
a. Percent processed within time frame specified in bylaws	100%	100%	Not available	100%	75%*	100%	93%
b. Percent of applicants granted temporary/expedited privileges	50%	<50%	Not available	50%	75%	13%	39%
People							
1. Active Staff	38	N/A	38	39	39	39	
2. All Medical Staff Members and Allied Health Professionals	83	N/A	83	85	88	92	
3. Locums/Temporary Staff	1	N/A	Not available	2	3	3	
Finance							
1. Number of applications processed	3	N/A	Not available	2	4*	8	14
2. Number of locum tenens applications	1	N/A	Not available	1	1	3	5

* One application received in June 2016 (last FY) was unattended during the MSO personnel changes and was completed during the Q2 reporting period of this FY. This application was not processed within the time specified in the bylaws. This application was excluded from all other metric analysis, as no relevant dates were known to calculate TATs.

LEGEND	
	Exceeds/far exceeds goal
	Meets goal
	Does not meet goal
	Far from meeting goal

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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: August 8, 2017
RE: Medical Executive Committee Report

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

1. **Policy/Procedure/Protocols/Order Sets (*action items*)**
   - *Childbirth Photography/Videotaping*
   - *Plan to Eliminate or Substantially Reduce Medication-Related Errors – MERP 2017*
   - *Anesthesia in Ancillary Departments*
   - *Hydrotherapy Pool Lippincott Procedure with Critical Notes & Consent*
   - *Fall Prevention and Management (with attachments)*
   - *Patient Transfer/Discharge to Another Facility*
   - *Medical Staff and Allied Health Professional Application Fee Processing*
2. **Core Privilege Forms by Service (*action items*)**
   - Pediatrics
   - Orthopedic Surgery
   - General Surgery
3. **Annual Reviews (*action item*)**
   - Pediatric Critical Indicators 2017
4. **Medical Staff Appointment/Privileges (*action item*)**
   - Arash Radparvar, MD (radiology – provisional active staff)
5. **Temporary Privileges for 60 service days in calendar year 2017, except where noted (*action items*)**
   - William Feske, MD (Bishop Radiology Group) – **90 calendar days**
   - Brian Mikolasko, MD (Hospitalist - locums)
   - Kathy Burck, MD (Hospitalist - locums)
   - Louisa Salisbury, MD (Pediatrics - locums) – pending the submission of proof of insurance

6. **Extension of Temporary Privileges (*action item*)**

    - Wilbur Peralta, MD (hospitalist) – extension of temporary privileges from 8/31/2017 to 12/31/2017 to provide necessary coverage of the hospitalist service.

7. **Advancements (*action item*)**

    - Jay K. Harness, MD (breast surgery) – advancement from provisional to full active staff

8. **Resignations (*action items*)**

    - Carolyn Saba, MD (anesthesiology) – effective 7/26/17
    - Shruti Ramakrishna, MD (family medicine) – effective 9/5/17
    - Manish Pandya, MD (internal medicine/hospitalist) – effective 9/1/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title:Childbirth Photography/Videotaping	
Scope:	Department:
Source: OB Nurse Manager	Effective Date:

PURPOSE:

To ensure that delivery procedures are conducted in the safest manner without interference from videography, voice recording, or photography

POLICY:

I. Video or voice recording, by any means, will not be allowed during delivery by vaginal birth, or by Caesarean Section with the following exception:

Video recording during these procedures by hospital personnel for a bone fide educational purpose or family special circumstance (i.e. spouse overseas in military) will only be allowed if permission to do so is granted by the delivering mother and the delivering physician.

II. Video recording will be allowed before delivery, after delivery, and after stabilization of mom and infant, with mom's consent and consent of the medical staff.

III. Photography will be allowed when consented to by mom, support person, and childbirth photographer (if applicable).

A. Staff will provide the following guidance for occasions in which photography may be allowed in the LDRP room and OR:
   1. Photography of procedures is not allowed (includes, but not limited to: vacuum or forceps delivery, the actual delivery, episiotomy or suturing, epidural placement, administration of medication to mom or baby, infant resuscitation).
   2. If directed, stop photography or videotaping due to a situation and request of medical staff until given direction to resume.
   3. Photography or videotaping of the fetal monitor strip or computer is not allowed.
   4. Photography, videotaping, or voice recording of medical staff will only be allowed if verbal permission is given.
   5. Photography and videotaping of the actual birth is not allowed. While educating the family, the visual representation of when the vaginal delivery procedure starts will be the provider putting on the sterile gown and gloves. At this time all photography/ videography must stop, and cannot resume until the provider gives verbal consent to resume videography/photography.
   6. In the OR, pictures may only be taken behind the drape of baby, mom, and mom's support person. Pictures may be taken of the baby at the warmer with permission of the newborn's delivery team. No videotaping allowed in the OR.
   7. Photography before and after delivery and stabilization of the newborn is allowed with mom's consent.

IV. NIHD will make every effort to provide photography, videotaping, and voice recording guidance to our patients during prenatal appointments and visits. Patients with no prenatal appointments or visits will be informed of NIHD guidelines upon admission for delivery.

PROCEDURE/EDUCATION:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Childbirth Photography/Videotaping	
Scope:	Department:
Source: OB Nurse Manager	Effective Date:

I. Consent: The childbirth photographer and mother will sign the consent to agree to abide by NIHD's policy for filming.

II. Educate family: The family will be educated to the above and given the consent to sign, either in the NEST upon pre-admission visit, or upon admission to the perinatal unit.

III. Nursing staff will notify the house supervisor if patient or visitors not willing to adhere to the hospital guidance.

DOCUMENTATION:

I. Documentation of the patient's wishes to photograph/videotape and the discussion should be consented and part of the medical record.

Committee Approval	Date
Peri-Peds Committee	7/21/17
NEC	
MEC	8/8/17
S&T	4/26/17
Board of Directors	

Revised 11/16sg;
Reviewed 6/11jk;
Supercedes 6/11

Northern Inyo Healthcare District

Plan to Eliminate or Substantially Reduce Medication-Related Errors 2017

Introduction

Northern Inyo Healthcare District operates a Critical Access 25-bed general acute care hospital is located in Bishop, California. Northern Inyo Hospital serves a rural population of approximately 18,000 residents of Inyo County, 10,000 square miles in area, located between the eastern slopes of the Sierra Nevada and the Nevada/California border.

For purposes of this plan, and in accordance with California Health and Safety Code 1339.63, a "medication-related error" means any preventable medication- related event that adversely affects a patient at Northern Inyo Hospital, and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Multi-disciplinary Process

The Pharmacy and Therapeutics Committee (P&T) is responsible for implementation of the Northern Inyo Healthcare District Medication Error Reduction Plan (MERP). The Pharmacy & Therapeutics Committee is a multi-disciplinary Medical Staff committee.

The Medical Staff Bylaws of 2/17/2016 establish the following:
The committee is composed of at least two active Medical Staff members, the Pharmacy Director, and the Director of Nursing (Chief Nursing Officer) or other nurse designee. Ex Officio members serving without vote include: Administrator, or the Administrator's designee and the Performance Improvement Coordinator. Representatives of Nursing, Laboratory (Bacteriology), Pharmacy, Surgery, Dietary, Respiratory Therapy, and Environmental Service departments may attend and participate in discussion.
The committee meets at least once each quarter. The committee is "responsible for development of all drug utilization policies and surveillance of all drug utilization practices within the Hospital, in a reasonable effort to assure optimum clinical results and minimal potential for hazard, subject to such approval by the District Board of Directors, and the Executive Committee of the Medical Staff.
The committee is accountable to the Executive Committee of the Medical Staff.

The Medication Administration Improvement Committee (MAIC), consisting of members of Nursing Administration, Pharmacy, Medical Staff, Ancillary services

and Performance Improvement was established in 2002 and revised in its composition in 2013. MAIC is a subcommittee of the P&T Committee. MAIC reviews all medication errors or near misses to determine cause and develop strategies for future prevention when needed. Policies and Procedures related to medication administration are reviewed in P&T Committee with input from MAIC team. MAIC findings are reported to P&T along with the indicators and any patterns found. MAIC meets monthly to complete concurrent and retrospective evaluations of medication errors and occurrences.

The Pharmacy and Therapeutics Committee with the help of the MAIC will evaluate, assess, and address each of the following:

Prescribing
Prescription order communications
Product labeling
Packaging and nomenclature
Compounding
Dispensing
Distribution
Administration
Education
Monitoring
Use

External Medication related error alerts will be made accessible to NIHD Staff:

1. ISMP Safety Alert newsletters will be distributed to Nurses and Pharmacists at NIHD via email.
2. Quarterly Action Agenda relative to ISMP alerts are reviewed at P&T committee. Actions are taken at the direction of the committee.

Annual Review of MERP:
The effectiveness of each of the systems within the MERP will be evaluated and reviewed at the P&T committee annually. The plan will be modified as warranted when weaknesses or deficiencies are identified. At NIHD the MERP will be approved annually by the P&T Committee.

Technology used at NIHD in the reduction or elimination of medication errors includes:
Paragon Health Information System (HIS) provides for automated allergy checking, automated dose checking, automated interaction checking, drug-lab rules engine, barcode medication administration and computerized physician order entry. The Paragon HIS provides a medication administration record that highlights due and overdue medications. The HIS has medication reconciliation modules for admission, transfer and discharge.
NIHD determined the need to change our hospital information system in 2017. A "Brain Trust" of employees and physicians was formed to determine the best option for future HIS; AthenaHealth was chosen. This will ensure cutting edge technology for the further safety of NIHD patients. AthenaHealth HIS should be implemented by October 2018.

Automated dispensing cabinet (ADC) updates - 2017 NIHD upgraded all Omnicell cabinets. These upgrades included:

- Controlled Substance Manager, which enables the pharmacy to trace and monitor the possession of controlled substances along all points in the distribution process
- Anesthesia Workstations, which give anesthesia providers instant access to medications, allow them to label medication syringes immediately to reduce medication errors and keep the medication secure at all times.
- Cabinets have the ability to label medications at the cabinet for medications not given immediately, such as IV piggybacks or creams and ointments.
- Anywhere RN allows nurses to remotely perform medication management tasks away from the ADC.
- The current cabinets were upgraded to include additional secure drawers with additional capacity for medications on each nursing unit.
- An additional Omnicell Cabinet was placed in Diagnostic Imaging to improve patient safety, medication security and pharmacy oversight.

The specific planned areas of assessment and improvement for 2017 are:

Prescribing:
CPOE - as a condition of Modified Meaningful Use 2, CPOE will exceed 70% as defined by CMS. Medication Order sets will be evaluated annually by P&T committee.

1. Meaningful use data on CPOE is reported to CMS by Quality RN and IT Department.
2. An Antibiotic Stewardship Program (ASP) metrics will be collected and reported to P&T. Pharmacy will be actively participate in this process.

Prescription Order Communication:
Verbal order policy was updated with an emphasis on reducing verbal orders except during emergencies or when physician is in a sterile procedure. This was done to decrease potential communication errors.

Product Labeling:
Review barcode scanning reports for barcodes that are not scanned and update barcodes. Barcode reports will be reviewed monthly by pharmacy; necessary updates will be done as appropriate.
Medication on sterile field in surgery is monitored to assure best practice for safe medication administration. (See Pillars of Excellence Surgery.)

Packaging and Nomenclature:
TNK and TPA abbreviations were removed from sound-alike/look-alike drugs in the ED. These high risk medications are now called by generic names only. This change was made as a recommendation from the ISMP quarterly action agenda.

Compounding:
We will assess the competency of pharmacy personnel in compounding in accordance with the Board of Pharmacy Sterile Compounding Licensure requirements.
Perform ASHP sterile compounding training for each staff member.

Dispensing:
Evaluate MAIC dispensing errors and make changes to improve the dispensing error

rate. After a near miss report of dispensing error, an evaluation was made to determine no other patients received the wrong medication. Result of investigation will be reported to P&T committee.

Distribution:
ADC was added to diagnostic imaging department. All medications are now secured and available to be signed out by approved staff. This has created a secure process for distribution of medications in this department.

Administration:
Use of barcodes for safe medication administration will be tracked quarterly. (See Pillars of Excellence for nursing units.) Nurse Managers have the ability to view barcode reports.

Medication Pass Tracers:
As part of Medication Tracer activity, a medication pass observation will be done across the continuum of care quarterly. The results will be reported to nursing administration and P&T committee. The observations will be used to educate nurses as to best practices. Training and changes in practice will be initiated as needed from the observations. (See Pillars of Excellence for Nursing Quality Department.)

Education:
Pharmacists and physicians received training on the Antibiotic Stewardship Program from a recognized professional organization. (Making a Difference in Infectious Disease Pharmacotherapy "MAD-ID")
The pharmacy will provide an hour of education during nursing orientation to include Omnicell training, medication security, High Risk-High Alert medications, Look Alike-Sound Alike Medications, multi-dose vials, infection control, drug information, safe Injection practices and basic pharmacy information.

Monitoring:
Drug/rules engine was added to monitor inpatient INR results on patients receiving warfarin.

Drug/rules engine was developed to study patients who receive insulin and have a lab value of less than 50. This report is followed by pharmacy and reported to CalHIIN.

Use:

1. Beta Blocker use prior to anesthesia. (See Pillars of Excellence Pre-op/PACU) Monitoring patient compliance, notification of physician when non-compliant to have opportunity to give med prior to surgery. Patient safety-outcome-evidence based best practice.
2. CalHIIN study of inpatient's who receive opiates is completed by pharmacy to determine if rescued with naloxone was required.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Anesthesia in Ancillary Departments	
Scope: Anesthesia, Perinatal, Emergency Department	Manual: CPM - Medication
Source: DON Perioperative Services	Effective Date:

PURPOSE:
To provide direction and clarification of requirements when anesthesia is administered in any department other than the Operating Room.

POLICY:
It is standard of practice at Northern Inyo Hospital to do procedures requiring anesthesia in the Surgical Suites. In the event that an anesthetic must be done in an ancillary department, such as the Emergency Room or Obstetrical Unit, the following procedure will be utilized.

EQUIPMENT:
1. Anesthesia Machine (from Operating room if necessary)
2. Appropriate monitoring equipment (Cardiac, Oximeter, CO2)
3. Suction equipment available
4. Emergency Medications available
5. Crash cart

PROCEDURE:
1. No flammable agents shall be used for administration of anesthesia
2. All electrical equipment must be fitted with grounding devices
3. The anesthetic equipment must be tested by the ~~anesthesiologist~~anesthesia provider prior to use
4. The anesthesia record must be maintained by the ~~Anesthesiologist~~anesthesia provider and become a part of the medical record. It must include dosage and duration of all anesthesia agents, other medication and all intravenous fluids including components.
5. All patients shall be monitored during the anesthetic in a way that is appropriate for the patient's condition and the anesthetic administered.
6. The ~~anesthesiologist~~anesthesia provider must remain with the patient as long as required by his condition and until responsibility for his care has been assumed by a qualified individual.
7. Patients must be rendered the same level of care as all anesthetized recovery patients. (See Post Anesthesia Care Unit for recovery guidelines.)
8. The release of the patient from an ancillary department following anesthesia may only be made by a physician.
9. Patients having received anesthesia must be discharged to a responsible individual

DOCUMENTATION:
Documentation of pertinent patient information must be noted on the anesthetic record following guidelines established for patients receiving anesthesia (see policy on Anesthesia record)

REFERENCE:
1. Title #22, #70237, # 70235, #70233, JCAHO 1933 SA. 1.5, SA. 1.6 JCAHO 1933 SA.2

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Anesthesia in Ancillary Departments	
Scope: Anesthesia, Perinatal, Emergency Department	Manual: CPM - Medication
Source: DON Perioperative Services	Effective Date:

Approval	**Date**
Surgery Tissue Anesthesia Committee	7/26/17
MEC	8/8/17
Board of Directors	
Last Board of Director review	1/18/17

Revised: 4/94, 7/17 AW
Reviewed: 01/98, 01/01; 12/2011BS TS, 10/21/12 PM
Index Listings: Anesthesia in Ancillary Departments; Anesthesia in Perinatal Unit; Anesthesia in Emergency Room

At NIHD we adhere to the following guidelines when using the labor pool/tub for labor pain management:

(to be used in LDRP room 4 only)

Have patient sign "Refusal to exit hydrotherapy pool" if refusing to get out against provider's advice

POLICY:

1. Laboring patients must have a support person readily available while in the tub.

2. Prior to use, the progres of labor, status of membranes, and position of the fetus must be assessed and documented.

3. Maternal vital signs should be within normal limits.

4. Fetal well-being shall be established and documented. Category II fetal strip will require physician order to use labor tub.

5. Water temperature ranges shall be maintained between 96-98 degrees for laboring moms.

6. Patients with ruptured membranes may use the tub at the discretion of the provider.

7. May utilize the pool with maternal A1 gestational diabetic patient.

PROCEDURE:

1. Obtain patient verbal consent to follow the above guidelines.

2. Provide education about the purpose and procedure for safe use of the labor tub.

3. Inflate the tub and insert the disposable liner (one patient use only) per manufacture's instructions.

4. Fill the tub to level, following manufacture's recommendation, and place clean linen and mat in bathroom.

5. Check maternal vital signs and fetal heart tones.

6. Assist pt into tub. Demonstrate use of tub and emergency call light system.

7. A nurse or support person must stay with the patient at all times while she is in the tub.

8. Evaluate and document FHR (Fetal heart rate) and contractions prior to hydrotherapy and thereafter according to the standards of care. Every 30 minutes by either doppler before, during, and after a contraction, or by use of the cordless telemetry monitor.

9. Slight maternal temperature elevation may be noted in the first 30 minutes while using the labor tub.

ADDITIONAL CONTRAINDICATIONS TO USE OF LABOR TUB:

1. Internal FSE (fetal scalp electrode) or IUPC (Intrauterine Pressure Catheter)

2. Pitocin infusion if continuous fetal monitoring is not possible.

3. First 1-hour period following misoprostil or other cervical ripening agents.

4. Regional anesthesia, narcotic medication less than 2 hours prior to using the tub, epidural, or nitronox use.

5. Excessive bleeding.

6. Multiple gestations.

GUIDELINES FOR EMPTYING AND CLEANING LABOR TUB:

1. Any floating debris that accumulates in the tub must be scooped out prior to draining the tub. Waste is discarded appropriately. Drain the tub per manufactor's instructions. Discard the liner.

2. The interior of the tub will be cleaned by housekeeping by wiping down with a hospital approved disinfectant. The thermometer must be cleaned with a hospital approved disinfectant.

3. Clean the surface with a non-abrasive cleaner.

4. Dry, then deflate and store until next use.

NORTHERN INYO HEALTHCARE DISTRICT

Hydrotherapy during labor

Revised: February 03, 2017

Introduction

Hydrotherapy is the use of water to promote well-being, whether in the treatment of illness or injury or as a way to provide relaxation and pain relief. Cold, warm, or hot water can be used for hydrotherapy using such methods as showers, tubs, foot baths, sitz baths, hot-water bottles, and warm or cold compresses.

Using hydrotherapy during labor can help relieve a patient's pain and anxiety and also promote relaxation of the pelvic muscles, possibly decreasing the duration of labor.[1] Research suggests that water immersion during labor improves placental perfusion. It has also been shown to increase maternal satisfaction and sense of control.[2] Although studies have produced conflicting results, some researchers have found that hydrotherapy significantly decreases the use of epidurals and IM and IV medications, decreases the need for episiotomies and instrumental deliveries, enhances fetal rotation, and promotes fast cervical dilation by increasing oxytocin release.[2][3]

The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics suggest that immersion in water during the first stage of labor may be associated with decreased pain or decreased use of anesthesia; however, there is no evidence to suggest that immersion otherwise improves perinatal outcomes. In addition, the safety of immersion in water during the second stage of labor has not been established and has not been associated with maternal or fetal benefits.[4]

Hydrotherapy during labor is provided in the form of a warm spray of water from a shower aimed at the lower abdomen, which can offer short-term pain relief and muscle relaxation, or a warm tub bath (optimally with Jacuzzi-type water jets or whirlpool action), which can provide therapy for several hours with the warm water lessening pain sensitivity, increasing circulation, increasing the production of endorphins, and producing a feeling of weightlessness.

Ruptured membranes typically don't preclude a patient's use of hydrotherapy because numerous studies have shown that hydrotherapy doesn't increase maternal or neonatal infections or other complications. However, contraindications to hydrotherapy do exist and may vary depending on the facility or the practitioner's preference. (See *Contraindications to hydrotherapy*.)

CONTRAINDICATIONS TO HYDROTHERAPY

Contraindications vary according to the facility's or practitioner's preference. Check to see whether these common contraindications apply to the patient:

- Gestational age less than 36 weeks or greater than 42 weeks
- Amnionitis
- Induction or augmentation of labor
- Placenta previa or abruption
- Vaginal bleeding
- Multiple gestation
- Premature rupture of membranes (more than 24 hours has elapsed)
- Meconium in the amniotic fluid
- Epidural in place
- Prior analgesia with drowsiness
- Maternal health problems, including asthma, diabetes, cardiovascular disorders, genital herpes, human immunodeficiency virus infection, urinary tract infection, hepatitis B or C, open wounds, recent surgery, and substance abuse

Equipment

- Bathtub (preferably with water jets)
- Bath blanket
- Several bath towels
- Washcloth

- Vital signs monitoring equipment
- Fetoscope or battery-operated Doppler device
- Bath thermometer
- Bath pillow
- Hospital-grade disinfectant
- Optional: patient gown

Preparation of Equipment

Drain and clean hydrotherapy equipment, such as the tub and water jets, after each patient's use and disinfect equipment surfaces and components with a hospital-grade disinfectant.[5][6][7]

Implementation

- If required by your facility, confirm that written informed consent has been obtained and that it's in the patient's medical record.[8][9][10][11]
- Perform hand hygiene.[12][13][14][15][16][17]
- Confirm the patient's identity using at least two patient identifiers.[18]
- Verify that the patient has no contraindications to hydrotherapy.
- Provide privacy.[19][20][21][22]
- Explain the procedure to the patient and discuss the benefits and risks of water immersion for labor.[23]
- Fill the tub halfway with water *to make sure that it doesn't overflow.*
- Use a bath thermometer to check the water temperature, *which should be at or around body temperature, between 95° and 101° F (35° and 38.3° C).*[23][24] Maintain the water temperature at the lower end of the stated range; warm it to the higher end of the range only if requested by the patient.[23]
- Obtain the patient's vital signs and the fetal heart rate (FHR), and assess contractions before the patient gets into the tub.
- Ensure the patient has undergone a vaginal examination before she enters the tub *to determine her labor progress.*
- Allow the patient to choose whether she wears a patient gown while in the tub. *Some patients may be too self-conscious about being in the tub undressed.* If the patient chooses to wear a gown, don't tie it *because it may pull on the patient's neck or get too tight while she's in the tub.*
- Enlist a second staff person to help you assist the patient into the tub *to maintain safety and prevent avoidable injuries.*
- Continue monitoring the FHR and maternal vital signs while the patient is in the tub. The frequency of assessment is based on what phase of the first stage of labor the patient is in, her condition, and the practitioner's orders or your facility's protocol. You can assess the FHR using a fetoscope or Doppler device without the patient getting out of the tub. Have the patient arch her back so that her abdomen rises out of the water or have her stand. Auscultate the FHR for 1 to 2 minutes at each assessment. (See the "Fetal heart rate monitoring, auscultation" procedure.)
- Palpate the patient's uterine fundus while she's in the tub *to monitor the frequency, duration, and strength of contractions and to assess for resting uterine tone.*
- Help the patient position herself in the tub. Sitting in an upright position tends to decrease the patient's pain perception and may help shorten the first stage of labor.

♦ ***Clinical alert:*** If the patient's membranes rupture while she's in the tub, immediately assess the FHR. If it has decreased or if meconium is observed in the fluid, immediately remove the patient from the tub, apply a fetal monitor, and notify the practitioner. If the FHR remains stable and there's no evidence of meconium, the patient may stay in the tub.♦

- Provide the patient with clear liquids while she's in the tub *to maintain hydration.*
- Observe the patient for signs and symptoms of light-headedness *because vasodilation can cause a sudden decrease in blood pressure.*

♦ ***Clinical alert:*** If the patient becomes light-headed, obtain her vital signs and the FHR immediately, provide her with a cool cloth to her face, and add cooler water to the tub. If the patient doesn't improve rapidly or the FHR decreases, assist the patient out of the tub.♦

- Observe the patient for vaginal bleeding, *which can indicate placenta previa or abruptio placentae.*
- Observe the patient for signs and symptoms of transition *because rapid labor progression is possible during hydrotherapy.*

- Encourage the patient's support person to sit next to the tub and massage her back and shoulders, provide fluids, and offer support.
- Continue hydrotherapy for the duration recommended by the practitioner, until the patient is ready to give birth or wants to get out, or until the patient or the FHR shows signs of possible compromise. The typical hydrotherapy duration is 1 to 2 hours.
- Enlist a second staff person to help you assist the patient out of the tub.
- Dry the patient immediately upon her leaving the tub *to prevent evaporation from causing a rapid cooling effect.*

♦ ***Clinical alert:*** If a patient must be removed from the tub quickly, wrap her in a bath blanket and assist her to the birthing bed. Have delivery supplies ready in the room.♦

- Perform hand hygiene.[12][13][14][15][16][17]
- Document the procedure.[25][26][27][28]

Special Considerations

- Encourage the patient to void every 2 hours *because a full bladder can impede the progress of labor by obstructing the passage and preventing the baby from moving into the pelvis.*

Complications

Complications associated with hydrotherapy include light-headedness; FHR changes, particularly decelerations; maternal or fetal tachycardia; and maternal palpations, chest or abdominal pain (not contractions), and variant changes in maternal vital signs.

Documentation

Record the FHR and the patient's vital signs as well as contraction frequency, intensity, and duration before and during the hydrotherapy. Document the patient's response to the therapy and its effectiveness in reducing her pain and anxiety and in promoting relaxation. Document when hydrotherapy was started and stopped and whether the patient experienced adverse effects or complications during hydrotherapy.

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(Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions)

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Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions

The following leveling system is from *Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice* (2nd ed.) by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt.

Level I: Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs)

Level II:	Evidence obtained from well-designed RCTs
Level III:	Evidence obtained from well-designed controlled trials without randomization
Level IV:	Evidence from well-designed case-control and cohort studies
Level V:	Evidence from systematic reviews of descriptive and qualitative studies
Level VI:	Evidence from single descriptive or qualitative studies
Level VII:	Evidence from the opinion of authorities and/or reports of expert committees

Modified from Guyatt, G. & Rennie, D. (2002). Users' Guides to the Medical Literature. Chicago, IL: American Medical Association; Harris, R.P., Hefland, M., Woolf, S.H., Lohr, K.N., Mulrow, C.D., Teutsch, S.M., et al. (2001). Current Methods of the U.S. Preventive Services Task Force: A Review of the Process. American Journal of Preventive Medicine, 20, 21-35.

At NIHD we adhere to the following guidelines when using the labor pool/tub for labor pain management:

(to be used in LDRP room 4 only)

POLICY:

1. Laboring patients must have a support person readily available while in the tub.
2. Prior to use, the progres of labor, status of membranes, and position of the fetus must be assessed and documented.
3. Maternal vital signs should be within normal limits.
4. Fetal well-being shall be established and documented. Category II fetal strip will require physician order to use labor tub.
5. Water temperature ranges shall be maintained between 96-98 degrees for laboring moms.
6. Patients with ruptured membranes may use the tub at the discretion of the provider.

PROCEDURE:

1. Obtain patient verbal consent to follow the above guidelines.
2. Provide education about the purpose and procedure for safe use of the labor tub.
3. Inflate the tub and insert the disposable liner (one patient use only) per manufacture's instructions.
4. Fill the tub to level, following manufacture's recommendation, and place clean linen and mat in bathroom.
5. Check maternal vital signs and fetal heart tones.
6. Assist pt into tub. Demonstrate use of tub and emergency call light system.
7. A nurse or support person must stay with the patient at all times while she is in the tub.
8. Evaluate and document FHR (Fetal heart rate) and contractions prior to hydrotherapy and thereafter according to the standards of care. Every 30 minutes by either doppler before, during, and after a contraction, or by use of the cordless telemetry monitor.
9. Slight maternal temperature elevation may be noted in the first 30 minutes while using the labor tub.

ADDITIONAL CONTRAINDICATIONS TO USE OF LABOR TUB:

1. Internal FSE (fetal scalp electrode) or IUPC (Intrauterine Pressure Catheter)
2. Pitocin infusion where continuous fetal monitoring is not possible.
3. First 2-hour period following misoprostil or other cervical ripening agents.
4. Regional anesthesia, narcotic medication less than 2 hours prior to using the tub, epidural, or nitronox use.
5. Excessive bleeding.
6. Multiple gestations.

GUIDELINES FOR EMPTYING AND CLEANING LABOR TUB:

1. Any floating debris that accumulates in the tub must be scooped out prior to draining the tub. Waste is discarded appropriately. Drain the tub per manufactor's instructions. Discard the liner.
2. The interior of the tub will be cleaned by housekeeping by wiping down with a hospital approved disinfectant. The thermometer must be cleaned with a hospital approved disinfectant.
3. Clean the surface with a non-abrasive cleaner.
4. Dry, then deflate and store until next use.

INFORMED CONSENT FOR HYDROTHERAPY POOL USE IN LABOR FOR PAIN MANAGEMENT

Patient's Name _____

In order to provide our patients with the best level of pain management during labor, we offer tub hydrotherapy. The tub is not meant to be used during active pushing in the second stage of labor or during delivery. The hydrotherapy tub does not allow for the effective management of shoulder dystocia (baby's shoulder gets stuck during delivery) or neonatal resuscitation (life-saving measures to support baby's heartbeat and breathing), if they are required. If I refuse to leave the hydrotherapy tub, I understand that providers may not be able to effectively prevent problems during delivery that could lead to disability, poor health, or death of the newborn. Some of the problems that may occur include: transient tachypnea of the newborn(baby struggling to breathe – fast breathing seen shortly after delivery), difficulty managing a tight nuchal cord effectively (cord wrapped around baby's neck), inability to manage shoulders that get stuck during delivery, and delay in assisting the baby to breathe and have a heartbeat, if needed. Delivery in the hydrotherapy tub also makes it difficult to treat postpartum hemorrhage (excessive bleeding by the mother after delivery).

I understand that my providers wish to provide an excellent and safe labor experience and that possibly cannot be achieved if I refuse to exit the hydrotherapy pool for delivery.

I hereby release all providers, the hospital and its agents from all responsibility for any injury or ill effects which may result if I refuse to exit the tub when asked.

Date_____Time_____AM/PM

Signature (patient) _____

If signed by other than the patient, indicate relationship._____

Witness_____Date:_____Time:_____

I declare that I have personally explained to the patient the risks and consequences involved in not exiting the hydrotherapy pool, the benefits of delivering in the safest setting, and the alternatives, if any.

Remarks_____

_____

_____

_____

Date:_____Time:_____AM/PM

Signature:_____

(Physician)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Prevention and Management	
Scope: Inpatient Departments, Emergency Department	Manual: CPM – Patient Safety (PS)
Source: DON ED & Inpatient Services	Effective Date:

PURPOSE:

A. Establish standards/criteria to identify patients who are at high risk of falling.
B. Identify methods to communicate high-risk status to staff, patient, and family.
C. Outline responsibilities of staff in relationship to the fall prevention program.
D. Outline procedures for documentation and communication.
E. Outline procedures after a fall has occurred.

POLICY:

A. Patients admitted to inpatient or observation services at Northern Inyo Hospital are assessed for being at risk of falling on admission, ~~and periodically~~ reassessed every shift, and assessed ~~and as needed~~ with changes in condition. ~~for fall risk.~~ Patients identified at risk for fallings ~~will~~ have a pPotential for physical injury. A Care Plan initiated and pPatients identified as high fall risk will have a Care Plan ~~n Interdisciplinary Plan of Care (IPOC)~~ developed to meet their individualized needs.

~~B. Fall prevention and screening in the outpatient clinic settings may be is done based on the patient's condition and within the scope of practice of the care provider. When an outpatient presents with a history of falls or the assessment/screening process indicates the outpatient may be at risk for falling, falls prevention strategies may be included in the patient's treatment plan, as appropriate, including education of the patient and/or caregivers. Additionally, the patient may be referred back to the primary care physician or referring physician.~~

~~C.~~B. Northern Inyo Hospital supports an interdisciplinary falls approach which facilitates:

1. Developing/reviewing of the fall prevention protocol
2. Assisting in implementation of fall prevention strategies
3. Acting as a resource as needed
4. Collecting and analyzing data on falls for common factors
5. Development of recommendations to reduce falls and fall-related injuries

C. Universal Fall Precautions: Northern Inyo Hospital District recognizes that any individual has the potential to fall. All employees are to be aware of and follow Universal Fall Precautions. These precautions are developed to protect the patient, visitors, and employees. (Attachment B)

D. All departments caring for patients will follow Universal Fall Precautions.(Attachment B)

E. For Perinatal Services: Also view the Fall Risk Prevention perinatal policy

F. For Perioperative Services: Also view the Positioning of the Surgical Patient policy

G. The Emergency Department will follow Universal Fall Precautions. All Emergency Department patients are considered at risk for fall or injury.

~~D.~~

FALL DEFINITION:

A. A fall is a sudden, unintentional descent, with or without injury that results in the patient coming to rest on the floor or against some other person/surface/object as ~~-(d~~Defined by

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Comment [LA1]: Gina, If a patient is a high f
risk, what documentation does the ED use? The f
committee suggested using the morse fall scale w
the initial assessment

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the National Data Base of Nursing Quality Indicators (NDNQI).

B. Falls can be divided into four categories:
   1. **Anticipated Physiological.** Patient's diagnosis or characteristics may predict their likelihood of falling (i.e. medications, unsteady gait, or post-surgery)
   2. **Unanticipated Physiological.** No obvious risk factors identified on assessment; falls related to conditions that were not anticipated (i.e. syncope, medication reaction, or seizure)
   3. **Accidental.** Environmental hazards, dropped infant
   4. **Developmental (pediatric only)** Non-injurious falls for infants/toddlers as they are learning to walk, pivot, run

C. Types of falls can include:
   1. Witnessed fall: Patient seen or in the presence of a staff member when the fall occurs.
   2. Un-witnessed: Fall is not observed by staff, and maybe reported at a later time after the fall occurred
   3. Assisted fall: Patient was assisted or lowered to the floor by staff.
   4. Unassisted Fallfall: Patient found on the floor or fell in the presence of staff but not assisted or lowered to floor by staff.:

INPATIENT FALL RISK ASSESSMENT AND PREVENTION:

A. Adult patients are assessed for fall risk using the Morse Fall Scale. (Attachment A).
B. Pediatric Patients are assessed for fall risk using the Humpty Dumpty scale. (Attachments E and F)
C. The RN assigned to the patient is responsible for assessing for fall risk. Risk assessments are completed:
   1. On admission to the hospital
   2. Every shift
   3. Upon transfer from one unit to another within the hospital
   4. Following a change in condition
   5. Following a fall

~~The following patients will be placed on Fall Risk Precautions:~~

D. Patients will be identified as:
   ~~1.~~ Standard fall risk: Morse Falls Score of 0-4425 or Humpty Dumpty Score of 7-11
   a.
D ~~High~~ Fall Risk: Morse Score >425 or Humpty Dumpty Score >11
   b.
      i. Any patient who has fallen during the current hospitalization
      ii. A patient who in the nurse's judgment is high risk for falls
      ~~2. A Morse Fall Scale total score of 45 or greater~~
      ~~3. A patient who in the nurse's judgment is high risk for falls~~
      ~~4. Any patient who has fallen during the current hospitalization~~

E. ~~The~~ Fall Risk protocol reduction interventions and the age appropriate Fall Prevention and Management Care Plan~~IPOC~~ is initiated by the RN on patients identified as high risk for falls.

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F. Patients who are impulsive, confused, have gait abnormalities or refuse to call for assist may receive additional interventions.

~~E.~~

~~**INPATIENT FALL RISK PROTOCOL:**~~

Fall Risk Reduction Interventions:

Standard Fall Risk Morse Score of <425 or Humpty Dumpty Score of 7-11:

The following will be initiated for all inpatients:

- -Orient Patient and Family to environment and routines
- -Place call light within reach, and remind Patient to use call light or bedrail call button to call for assistance.
- -Ensure that the Patient bed is in low position and the brake is on.
- -Place Patient's necessary items within reach.
- -Provide non-skid footwear for Patient as needed.
- -Minimize environmental trip/slip hazards.
- -Round frequently and assess for safety and comfort (4 P's: Potty, Position, Pain and Periphery)
- -Provide necessary ambulatory aids.
- -A potential for physical injury care plan related to hospitalization will be initiated on all Patients.
- -Provide ~~NIHD~~patients and families with a Fall Risk Brocshure.

~~• Communication: Fall Risk Protocol:~~

High Fall Risk Interventions Morse Score >425 or Humpty Dumpty Score >~~11~~11:

In addition to the Standard Fall Risk interventions listed above, more intensive interventions by the health care team are warraented for all those pPatients identified as high fall risk. They include but are not limited to the following:

- –Upon completion of a nursing assessment, if the Morse Falls Scale is >425 or Humpty Dumpty Score >11, a Physical Therapy referral will be generated.
- –Potential for physical injury from falls cCare pPlan will be initiated.
- Relocate pPatient to an observation room near the nNurse's sStation.
- –Activate the bed alarm and or chair alarm if indicated.
- –A gait belt will be used during transfers and ambulation for all hHigh fFall rRisk pPatients.

1. The RN is responsible for initiating the Fall Risk Protocol and assuring the protocol implementation.
   a. High risk for falls is communicated in the following fashion:
      i. Falls risk yellow tile~~sign~~ on the room plaque along with a yellow falling star sign
      ii. Yellow non-skid socks are given to the patient to wear during ambulation
      iii. Bed alarm signs are hung at the head of the patients~~patient's~~ bed and on the door frame~~jam~~ if indicated.

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iv. A yellow Fall Risk armband is applied at the time the patient is identified as high risk; (The armband application is documented in the EHR. Communication of the patients fall risk will be included during any handoff with an SBARQC handoff report regarding fall risk status.

v. Shift hHuddle on the Acute/Sub Acute Services Department will include identification of High Fall Risk Patients.

~~iv.~~vi. Safety issues will be discussed daily at the interdieiplinaryinterdisciplinary patient care conference.~~.~~

2. Individualized Plan of Care interventions are chosen according to the patient's area of identified need.
   a. Identify the individual patient falls risk factors and implement interventions to decrease their risk of falling.
      i. RN will review medication for contributing to increase risk for falls Discuss any medication risk concern with the physician and provide education to patient regarding medications and falls risk.
         1. Some Medicationss on the EMAR will be flagged: "MAY INCREASE FALL RISK" including but not limited to:
            a. Antidepressants: amitriptyline, doxepin, imipramine
            b. Antiemetics: Compazine, Phenergan
            c. Antihistamines: Benadryl, Atarax
            d. Benzodiazepines: Ativan, Valium, Midazolam
      ii. If unsafe mobility is a risk factor consider:
         1. Physical Therapy referral
         2. Supervised transfers and toileting
         3. Ensure any walking aides and commode in reach
         4. Follow mobility plan to increase strength and balance
      iii. If frequent toileting is a risk factor consider:
         1. Evaluate and discuss with physician any possible treatments/interventions regarding the increased frequency (i.e. infections, medications, incontinence)
         2. Offer scheduled assisted toileting
         3. Review medications that may increase toileting and try to not schedule near bedtime
         4. Keep toileting aides near patient
         5. If the patient is impulsive or confused consider the use of a safety attendant (Refer to Policy "Patient safety attendant or 1:1 staffing guidelines)
      iv. If confusion is a risk factor consider;
         1. Increased observation in a hHigh visibility room with door ~~open~~ (Unless privacy needed)
         2. Hall window shades to remain open (Unless privacy needed)
         3. Frequently orient to surroundings
         4. Avoid intercom usage or loud noises

5. If confusion is not the baseline, RN to assess for possible contributing factors (i.e. infection, medication, electrolyte imbalance. . .)
6. When patient is in a chair, a chair alarm will be used
7. When patient is in bed, a bed alarm will be used

b. Consider the use of a fall alarm under the following circumstances:
   i. Evidence of confusion or "sun-downing"
   ii. Impulsive behavior
   iii. Patient exhibits either of the above and are at higher risk for injury from anticoagulant therapy or bone related issues such as osteoporosis or bone metastasis, and/or
   iv. Repeated failure to remember to request help when getting up.
   v. If the patient/refuses the fall alarm, document this refusal in the EHR.

3. Care Plan~~IPOC~~ includes patient/family education to assist the patient/family in understanding risk and steps to decrease the risk.
4. Patient's response to the Care Plan teaching~~IPOC~~ is evaluated and documented.
5. Care Plan~~IPOC~~ is updated as necessary based on the patient's condition and identified areas of risk for falling.
6. Family and patients receive the fall prevention brochure upon admission

MANAGEMENT OF THE IN-PATIENT POST FALL:

A. Post fall management is to be implemented on a witnessed fall, un-witnessed fall, assisted fall, or unassisted fall. (See Fall definition ~~of a fall III. B~~Page 1 & 2 / C 1 thru 4.)
B. The RN will initiate the Post Fall Care Phase of the Fall Prevention and Management ~~Care Plan IPOC~~.
C. The RN will complete an immediate post fall patient assessment and document the following information ~~on the post fall assessment form in the~~the EHR ~~EHR~~ including but not limited to: ~~This includes:~~
   a. Evaluation of the fall:
      a. Date and /time of fall
      b. Patient assessment at time of fall:
         i. Assessment of injuries (Attachment C)
      ~~c. Witness (name of individual(s) involved), or unwitnessed.~~
      ~~d. Location of the fall~~
      ~~e. Patient description of fall (when possible)~~
      ~~f. Activity at time of fall.~~
      ~~g. Circumstances or special conditions at the time that may have contributed to the fall.~~
      ~~h. Environmental safety in place at time of the fall~~
      ~~i.~~c. Evaluation of patient injuries based upon interventions
   b. Patient vital signs
   c. Pain Assessment
   d. Physical assessment to include but not limited to the following systems:
      a. Neurological

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b. Glascow coma scale
c. Musculoskeletal ~~and~~
d. Integumentary ~~assessments~~

e. Morse Fall risk re-assessment after the fall

D. Notification of the fall.

~~D.~~ The RN is responsible for:

a. Physician notification of fall

~~a.~~b. A physician is notified immediately when the patient has any injury identified, is unresponsive, has evidence of spinal cord injury, or significant injury (outlined in addendum C)

~~b.~~c. If no injury present a physician must be notified as soon as possible.

~~c.~~d. Documentation of the physician notification is to be completed ~~on the "Notification Form~~Post fall assessment~~"~~ in the EHR.

~~b.~~e. Notification of family/guardian or documentation that the patient did not want the family notified (If patient is alert and oriented)

f. Immediate ~~Level IV RN/ Lead RN for the shift~~notification to the shift charge if available

g. Immediate notification to the House Supervisor

~~c.~~h. Notification to the Department Manager

E. The RN caring for the patient in conjunction with the individual ~~that~~ who discovered the patient ~~(when the patient is not assigned to a RN, the person that found the patient)~~ is responsible for completing a Quality Review Report (QRR). The QRR should be completed at the time of the fall or by the end of the shift.

F. Document additional information regarding the patients fall ~~, not included on the post fall assessment documentation form on a Clinical Supportive Note in the "Documents" menu tab of~~in the EHR: Information may include but is not limited to:

~~a. Description of circumstances surrounding the fall~~

~~a. Any symptoms experienced prior to the fall~~

~~b. Statements made by the patient/family concerning what the patient , was doing at the time of the fall~~

~~c. Any additional subjective or objective notes regarding the fall~~

~~b.~~a. Measures taken to provide patient safety (Initiation or adjustment to the plan of care)

~~c.~~b. Notification of family or documentation that the patient did not want the family notified (If the patient is alert and oriented)

G. The ~~Lead~~ RN will complete the following:

a. Convene a "Post fall huddle debrief" to review the plan of care to assure appropriate interventions are in place and debrief the circumstances of the fall.

b. Assure that ~~an~~ QRR along with a Post Fall Huddle Debrief form is completed with all necessary information. Notify the nurse manager/director of the fall.

H. If the fall results in death or permanent functional injury, notify Performance Improvement who will initiate a Sentinel Event and CDPH Adverse Event Management and Reporting Plan. During non business hours, notify the Administrator on call (AOC).

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Prevention and Management	
Scope: Inpatient Departments, Emergency Department	Manual: CPM – Patient Safety (PS)
Source: DON ED & Inpatient Services	Effective Date:

~~For falls prevention in Surgical Services, Same Day Center, Women's and Children's Services and Emergency services see unit specific policies/standards of care.~~

NORTHERN INYO HOSPITAL STAFF RESPONSIBILITIES:

A. All staff are responsible to:
   1. Create and maintain a safe environment
   2. Notify the proper individual of unsafe situations
   3. Communicate high risk fall status
   4. Comply with universal and high risk for fall precautions
   5. Develop an individualized patient plan of care as appropriate to scope of practice.

B. Managers are responsible to:
   1. Implement specific falls protocol on the unit level
   2. Assure compliance with the falls protocol
   3. Provide a safe environment
   4. Maintain appropriate equipment in collaboration with facility equipment experts to aid in fall prevention
   5. Ensure that staff receives education about fall prevention
   6. Review falls data for the unit and provide feedback and coaching for fall prevention to staff

C. In-patient staff nurses are responsible for the implementation and oversight of individual patient fall prevention:
   1. Assess/reassess for fall risk
   2. Communicate when the patient is at high fall risk
   3. Collaborate with the interdisciplinary team in prevention of falls
   4. Develop the appropriate Care Plan for~~/~~t fall prevention.~~IPOC~~
   5. Educate the patient and family on the plan of care and fall risk prevention strategies
   6. Assure implementation of the high fall risk interventions by the team
   7. Evaluate the patient's response to the Care Plan teaching/interventions.~~IPOC~~.
   8. Manage a patient after the fall.

D. Charge Nurse or nurse caring for the patient:
   1. Responsible for immediate post fall huddle and documentation in the Post Fall Debriefing form which will be attached to the QRR
   2. Assure post fall QRR is completed by the RN responsible for the patient
   3. Notify the house supervisor if a patient fell during off hours
   4. Notify the director, manager, or house supervisor of falls that results in significant injury such as fracture or death.
   4~~.~~5.Discuss the ~~Fall~~fall and other p~~P~~atient safety issues at the daily ~~Interdiciplinary~~Interdisciplinary plan of care conference.

E. Clinical staff educators:
   1. Review of falls in assigned clinical areas
   2. Consultation on high fall risk patient as needed
   3. Review and analyze aggregated data
   4. Review and develop falls risk protocols
   5. Develop educational programs and competencies for nursing staff

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Prevention and Management	
Scope: Inpatient Departments, Emergency Department	Manual: CPM – Patient Safety (PS)
Source: DON ED & Inpatient Services	Effective Date:

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Supercedes:
Falls Prevention Reminders
Fall risk Assessment in the Emergency Department
Fall Risk Assessment –Med-Surg

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fall Prevention and Management	
Scope: Inpatient Departments, Emergency Department	Manual: CPM – Patient Safety (PS)
Source: DON ED & Inpatient Services	Effective Date:

Fall Risk Assessment -ICU

CROSS REFERENCE P&P:

~~1 Falls Prevention Reminders~~
~~2 Fall risk Assessment in the Emergency Department~~
~~3 Fall Risk Assessment Med-Surg~~
~~4 Fall Risk Assessment -ICU~~
1. ~~5~~ Safety Policy for Perinatal Unit Patients
   ~~6~~ Gait Belt Policy
   ~~7~~ Functional Risk Assessment Criteria for Therapy referral
   ~~8~~ Pediatric Standards of Care and Routines
   Positioning of the Surgical Patient
   Patient Safety attendant or 1:1 staffing guidelines
~~Fall Risk Prevention Perinatal~~
2. ~~_____~~

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Approval	Date
CCOC	6/19/17
Fall and injury Prevention Committee	6/8/17
Safety Committee	7/12/17
Med Services/ICU	7/27/17
Peri/Peds Committee	7/21/17
MEC	8/8/17
Board of Directors	

Developed: 5/~~2~~/17la
Reviewed:
Revised:
~~Supercedes~~Supersedes:
Index Listings:

Morse Fall Scale Attachment A

Risk Factor	Scale	Score
History of Falls	**Yes** Recent falls (occurred in the previous 3 months) or any fall that occurs during hospitalization	25
	No falls in last 3 months	0
Secondary Diagnosis	**Yes** If the physician has listed more than one complaint or diagnosis.	15
	No if only 1 diagnosis	0
Ambulatory Aid	**Furniture** Ambulates clutching onto a person, furniture or a wall for support	30
	Crutches / Cane / Walker	15
	None / Bedrest / Wheelchair / Nurse Patient walks without a walking aid, uses a wheelchair or is on bed rest and does not get out of bed at all.	0
IV / Saline Lock	**Yes** If the patient has either an IV infusing or a saline lock.	20
	No intravenous apparatus.	0
Gait / Transferring , If the patient is in a wheelchair, the patient is scored according to the gait used when transferring from the wheelchair to the bed.	**Impaired** Impaired Gait: Patient may have difficulty rising from a chair, may need to push on the arms of the chair or bounce in order to rise. Patient walks with head down/watches the floor or can't walk without assistance. Uses furniture or handrails to walk, with knuckles that turn white.	20
	Weak Patient takes short, shuffling steps and tends to walk with a stooped posture. Is able to lift head while walking without losing balance. If the patient needs support touches furniture with a light touch for reassurance rather than grabbing the furniture to remain upright.	10
	Normal / Bed Rest / Immobile Normal Gait: Patient walks confidently, with head erect, arms swinging freely at the side. The patient's stride is not hesitant. Or patient is immobile (bedbound or wheelchair bound).	0
Mental Status Ask the question: Are you able to go to the	**Overestimates or Forgets Limitations** Over estimates or forgets limits-If the patient's response is not consistent with physician's orders or if the patient's assessment of their own ability is unrealistic.	15

bathroom alone or do you need assistance? Mental status refers to the patient's awareness to of their limitations concerning their own mobility and the physician's order of mobility:	**Oriented to Own Ability** - Knows limits - If the patient's reply in judging his or her own ability is consistent with the physician orders.	
Morse score obtained by adding together each category		Total =

I. Scoring of the Morse Fall Scale:
   1. Total Score is a result of adding together the individual score from each of the risk factors. **Patients are considered high risk for falls when the total score is greater than or equal to 45 Points.**
   2. Gait/Transferring:
      a. Consider patients with a diagnosis of dementia or delirium as someone who would be at risk for forgetting limits.

Attachment B

Universal Fall Precautions

1. Orient the patient/family to the environment and the potential for falls.

2. Non-skid footwear/slippers/socks when ambulating. Yellow non-skid slipper socks denote high fall risk patient only.

3. Assure that the bed is in low position when care is not being given.

4. Wheels on a bed, gurney, wheelchair, and BSC (if locks present) are locked when appropriate.

5. Spills are wiped up immediately.

6. Call light/telephone/water/personal items are within reach.

7. Ensure side rails are placed in the up and locked position on the side the patient will be turning toward for safety.

8. Bed Side rails up x3. Bottom side rails up can impede a safe exit from the bed and should only be used to keep the patient from sliding out of bed.

9. Ensure a safe environment (no spills pick up clutter and remove "trip" items, such as electrical cords and unnecessary equipment).

10. Assure that the room is properly lit.

11. If a medication is given that can affect balance or sedation - Inform the patient and ask them to “Please Call, Don't Fall".

12. Consider peak effect for prescribed medications that affect drowsiness, gait, and elimination and plan care accordingly.

13. Ambulate patients early and often to ensure conditioning and strengthening and decrease fall risk.

14. Defective equipment or hazards are reported immediately.

Post Fall Physical Assessment

I. When a fall occurs it is important to perform a rapid and focused assessment to assess for physical injuries.

II. Immediate Assessment

A. Responsiveness –

B. ABCs - Airway, Breathing, & Circulation.

1. If unresponsive and not breathing- logroll the patient onto their back - ' careful to maintain alignment of the neck and careful of any injuries to the: extremities and initiate BLS and call a Code Blue.
2. If loss of consciousness - Call a Code Blue. Do not move patient unless BLS needs to be initiated.
3. If conscious but a spinal cord injury is suspected-Do not move the patient; notify the Emergency Room STAT for institution of spinal cord precautions. As needed transport to ED for further trauma care by the ED physician.
4. Alert and no evidence of spinal cord injuries - assess for fractures, especially symmetrical ROM/shortening or external rotation of lower, extremities. If suspect fracture notify the patient's physician STAT before, moving if possible. Care to be given according to physician responding or minimally as outlined below.

C. If responsive and no evidence of the above injuries with either no head trauma or minor head trauma present:

1. Vital signs
2. Neuro checks to include LOC and pupils
3. If diabetic, check blood glucose as ordered by physician
4. Note presence of pain from the fall, the degree of pain and location
5. Assessment of lacerations, abrasions, contusions or other injuries and treatment given
6. Vital signs, pain assessment, neuro checks and assessment of injuries to be completed and documented:
   a. Immediately
   b. then per physician order or unit standard

D. The physician must be notified as soon as possible for consciousness, no head trauma or minor head trauma. The physician must be notified STAT when the patient is unresponsive; there is evidence of spinal cord injury or head trauma or significant injury such as a fracture.

Attachment E

Humpty Dumpty Falls Prevention Program™

Preventing falls, enhancing safety.

Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Parameter	Criteria	Score (circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to own ability	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4
	Patient uses assistive devices or Infant-Toddler in Crib or Furniture/Lighting (Tripled room)	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/ Anesthesia	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage	Multiple Usage of: Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives/Diuretics Narcotics	3
	One of the meds listed above	2
	Other Medications/None	1
	Total	

At risk for falls
If score is 12 or above

Minimum Score 7
Maximum Score 23

☞ Patient Falls Safety Protocol on back

Attachment E

Patient Falls Safety Protocol

Low Risk Standard Protocol (score 7-11)

- Orientation to room
- Bed in low position
- Side rails x 2 or 3 up, assess large gaps, such that a patient could get extremity or other body part entrapped, use additional safety procedures.
- Use of non-skid footwear for ambulating patient, use of appropriate size clothing to prevent risk of tripping
- Assess elimination need, assist as needed
- Call light within reach, educate patient/family on its functionality
- Environment clear of unused equipment, furniture's in place, clear of hazards
- Assess for adequate lighting, leave nightlight on
- Patient and family education available to parents and patient
- Document fall prevention teaching and include in plan of care
- Consider floor mats

High Risk Standard Protocol (score 12 and above)

- Complete all Low risk standard protocol as noted above
- Identify patient with a yellow wrist band and falling star on door frame
- Educate patient/parents of falls protocol precautions
- Check patient minimum every 1 hour
- Accompany patient with ambulation
- Developmentally place patient in appropriate bed
- Consider moving patient closer to nurses' station
- Assess need for 1:1 supervision
- Evaluate medication administration times
- Remove all unused equipment from the room
- Protective barriers to close off spaces, gaps in the bed
- Keep door open at all times unless specified isolation precaution are in use
- Keep bed in the lowest, unless patient is directly attended
- Documents in nursing narrative teaching and plan of care

Definitions to assist in grading the Humpty Dumpty Falls Assessment Scale

The Humpty Dumpty Falls Assessment Scale requires nursing judgment and individualization to each patient.

- Age- Parameter can be based on chronological or developmental age of the patient.

- Gender- Self explanatory

- Diagnosis- (Associated symptoms that put patient at risk for falls).
  - If the patient has multiple, secondary or underlying diagnosis then the score is based on the highest acuity diagnosis. (example- a sickle cell patient with history of strokes of seizures would receive the higher neurological score
  - Examples of diagnosis include but are not limited to
    - Neurological- seizures, head traumas, hydrocephalus, cerebral palsy, etc. This would include patients being worked up for neurological diagnosis.
    - Alterations in oxygenation- This category encompasses any diagnosis that can result in the decrease in oxygenation to the brain or a decrease in oxygen carrying ability of the red blood cells. Alteration in oxygenation goes beyond respiratory diseases and may include dehydration, anemia, anorexia, syncope, etc.
    - Psychiatric/Behavioral disorders- can include mood disorders (major depression, bi-polar disorder) and impulse control disorders
    - Other diagnosis- anything that does not fall into the other categories (examples include but not limited to cellulites, orthopedics)

- Cognitive Impairments- (1- Awareness of one's ability to function and perform ADLs; 2- Not necessarily based on age rather on physiologic components that affect cognitive awareness).
  - Not aware of limitations- Can be any age group and is dependent on inability to understand the consequences to their actions. (Example- severe head trauma, infancy).
  - Forgets limitations- Can be any age group. The child has the ability to be aware of their limitations however do to the factors such as age, diagnosis, current presenting symptoms, or current alteration in function (such as weakness or hypoglycemia) the child forgets their limitations. Can include children prone to temper tantrums.
  - Oriented to ability- Able to make appropriate decisions, understanding consequences of actions.

- Environmental Factors
  - History of Falls- during admission or previous admission.
  - Infant/toddler placed in bed- Inappropriate placement of infant/toddler in a bed versus a proper placement in a crib
  - Patient uses assistive devices- includes but not limited to crutches, walkers, canes, splints.
  - Infant/toddler in crib- appropriate crib placement.
  - Furniture/Lighting- multiple pieces of furniture or pumps/low lighting in the room.

- Patient placed in bed- appropriate bed placement.
- Outpatient area- inpatient receiving services in an outpatient area.

- Response to Surgery/Sedation/Anesthesia- Patient received one within the allotted time frames. Not including bedside procedures without anesthesia.

- Medication Usages- Purpose of this section is to identify patients who may be at risk for alteration in level of consciousness due to medications that affect cognitive awareness. Medications that are included in any for the medications categories are included, including seizure medications.

Post fall assessment tab to include:

a. Date and time of fall
b. Equipment used to lift patient up and back into bed or into chair
c. Patient assessment at time of fall:
d. Evaluation of patient injuries based upon interventions

2. Patient vital signs
3. Pain Assessment
4. Neurological check to include level of consciousness and pupil reaction
5. Responsiveness
6. Glascow coma scale
   a. Musculoskeletal
   b. Integumentary include lacerations, abrasion, contusion or other injuries and treatment given
7. Morse Fall risk re-assessment after the fall
8. Date and time the physician was notified of the fall along with response.

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

Post Fall Debriefing for Employees and Visitors

Not a permanent part of the record

**Please Complete the Following After Each Employee or Visitor Fall*

**This form must be completed and attached to a QRR prior to the end of the shift when the fall occurred*

**Please Complete and submit a QRR prior to the end of the shift when a fall occurs*

Employee or visitor Name: _____

Date of fall: _____ Time of fall: _____

Department: _____ Exact fall location: _____

Fall witnessed by: _____ Fall witnessed by: _____

Fall witnessed by: _____ Form completed by: _____ Date: _____ Time: _____

Immediate Assessment: (If 2-4, notify AOC or Performance Improvement immediately)

1	Alert and oriented, no signs of spinal cord injury	3	Loss of consciousness
2	Conscious but spinal cord injury is suspected	4	Unresponsive and not breathing

Name of physician notified: _____ Date: _____ Time: _____

Name of family notified: _____ Date: _____ Time: _____

If family not notified, state reason: _____

Did the fall inflict pain on the individual? Pain scale: /10 Relief given: Yes No N/A

Evaluation of patient Injuries including areas of pain:

Did the individual receive treatment for injuries? If yes, what was the treatment If no, state why. (Did individual refuse tx?)

Individuals' description of fall (when possible):

Activity at time of fall:

Any statements made by the individual or family concerning what the patient was doing at the time of the fall:

List any medications that the individual was on that could have contributed to the fall if able to obtain:

Circumstances or special conditions at the time that may have contributed to the fall:

Any symptoms experienced prior to the fall:

Universal fall precautions and environmental safety in place at time of fall? Answer either **Yes** or **No** to all:

Ground/floor free from clutter	Y / N	Electrical cords stored correctly	Y / N
Ground/floor free from ice/snow/water	Y / N	Was there adequate lighting	Y / N
Individual Wearing Non skid footwear	Y / N		

Explain any no answers noted above:

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

Post Patient Fall Debriefing

Not a permanent part of the record

**Please Complete the Following After Each Patient Fall*
**This form must be completed and attached to a QRR prior to the end of the shift when the fall occurred*
**Please Complete and submit a QRR prior to the end of the shift when a fall occurs*

Patient Name: _____ Medical Record #: _____ Encounter #: _____
Date of fall: _____ Time of fall: _____
Department: _____ Exact fall location: _____
Fall witnessed by: _____ Fall witnessed by: _____
Fall witnessed by: _____ Form completed by: _____ Date: _____ Time: _____

Immediate Assessment: (If 2-4, notify AOC or Performance Improvement immediately)

1 Alert and oriented, no signs of spinal cord injury
2 Conscious but spinal cord injury is suspected
3 Loss of consciousness
4 Unresponsive and not breathing

Morse fall scale reassessment: Prior to fall: /125 After fall: /125
Name of physician notified: _____ Date: _____ Time: _____
Name of family notified: _____ Date: _____ Time: _____
If family not notified, state reason: _____
Did the fall inflict pain on the individual? Pain scale: /10 Relief given: Yes No N/A
Evaluation of patient Injuries including areas of pain:

_____

Treatment received for injuries:

_____

Patient description of fall (when possible):

_____

Activity at time of fall:

_____

Any statements made by the patient or family concerning what the patient was doing at the time of the fall:

_____

List any medications that the patient was on that could have contributed to the fall:

_____

Circumstances or special conditions at the time that may have contributed to the fall:

_____

Any symptoms experienced prior to the fall:

_____

Universal fall precautions and environmental safety in place at time of fall? Answer either Yes or No to all:

Bed in low position	Y / N	Call light/telephone were within reach	Y / N
Siderails up X3x3	Y / N	Water/personal items were within reach	Y / N
Floor dry/free from clutter	Y / N	Non skid footwear on patient	Y / N
Hourly rounds done per policy	Y / N	Wheels/bed, wheelchair, gurney locked	Y / N
Room properly lit	Y / N	Electrical cords stored correctly	Y / N

Explain any no answers noted above:

Revised: 5/23/17

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Transfer/Discharge to Another Facility	
Scope: ED and Inpatient Services	Manual: CPM – Admission, Discharge, Transfer (AI
Source: ~~Day Shift Nurse Supervisor~~CNO	Effective Date:

PURPOSE:

1. To provide appropriate diagnostic or treatment facilities, or needed specialists that are not available at Northern Inyo Hospital to meet the care needs of a patient.
2. To prevent an individual's condition from deteriorating if not transferred to a specialized care center.
3. To accommodate requests from any individual or family for transfer to another facility, when the transfer will not jeopardize the individual's condition.
4. To provide beds when no beds are available.
5. To provide convalescent care.

POLICY

Northern Inyo Hospital will provide emergency services and care including appropriate medical screening examination and evaluation within the capability of its facility and staff, to any individual requesting, or for whom services or care is requested, for any condition in which an individual or unborn child is in danger of loss of life or serious injury or illness. This service and care will be rendered without first questioning the individual or any other person as to his or her ability to pay, and care thereafter will not be delayed based on insurance status or method of payment.

Northern Inyo Hospital will not discriminate in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sexgender, pre-existing medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sexgender, pre-existing medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the individual. When necessary, examination and evaluation will include consultation with appropriate specialists. Such consultation may be by telephone.

Physicians who serve on an "on call basis" to the emergency department cannot refuse to respond to a call on the basis of any of the factors listed above. Any on-call physician who refuses to respond appropriately will be listed on the appropriate form. Individuals will be notified of their rights as required under Section 76:1317.3 (d) of the Health and Safety Code. This is posted ~~on the bulletin board outside the emergency room office (see page 4 of transfer policy).~~in the Emergency Department waiting room.

Comment [LA1]: Where is this located?

No individual will be arbitrarily transferred. The receiving physician and facility must consent to accept the individual, and the individual must be sufficiently stabilized for transport. Any individual who is unstable must have documented individual request for transfer or physician certification of medical need for transfer. Responsibility for the patient during transfer must be established. While we gradually relinquish control of care, the hospital always has some responsibility for the patient until they leave. Staff members need to make sure that documentation is complete for care rendered while here in the hospital.

~~**PURPOSE:**~~

~~1. To provide appropriate diagnostic or treatment facilities, or needed specialists that are not available at Northern Inyo Hospital.~~
~~2. To prevent an individual's condition from deteriorating if not transferred to a specialized care center.~~
~~3. To accommodate requests from any individual or family for transfer to another facility, when the transfer will not jeopardize the individual's condition.~~
~~4. To provide beds when no beds are available.~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Transfer/Discharge to Another Facility	
Scope: ED and Inpatient Services	Manual: CPM – Admission, Discharge, Transfer (AI
Source: ~~Day Shift Nurse Supervisor~~CNO	Effective Date:

~~5. To provide convalescent care.~~

PROCEDURE:

1. The receiving institution must be informed of the transfer and positive acceptance of the individual obtained prior to making any transportation arrangements.
2. For all emergent transfers t~~T~~he referring physician must establish direct communication with the receiving physician. This responsibility should not be left to the nurse or other hospital staff members.

~~1.~~ 3. Non-emergent transfers may be arranged at the direction of the physician but do not require physician to physician report.

~~2.~~ The Nursing or Social Service staff may call the ambulance or transfer service. The physician will determine the level of medical personnel to accompany the individual following their appropriate scope of practice in agreement with receiving physician. See guidelines for interfacility transfer policy ~~in appropriate manuals.~~.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Transfer/Discharge to Another Facility	
Scope: ED and Inpatient Services	Manual: CPM – Admission, Discharge, Transfer (AI
Source: ~~Day Shift Nurse Supervisor~~CNO	Effective Date:

~~**PROCEDURE: (continued)**~~

4.

~~3.~~ 5. Prior to transfer, the individual's condition must be stabilized as agreed upon by the transferring and receiving physicians. All appropriate medical treatment will be provided (within NIHD capacity) to minimize the risks to the individual or unborn child.

~~4.~~ 6. Written doctor's orders, physician transfer summary (if separate from transfer form), transfer form, and copy of Northern Inyo Hospital Face Sheet must accompany all individuals. Pertinent medical records and copies of all the appropriate diagnostic tests results, which are reasonably available, are transferred with the person.

~~5.~~ 7. When ~~local~~ ambulance services are used for emergency transfers, a copy of the transfer record will be provided to the ~~receiving hospital~~ambulance service.

~~6.~~ 8. Where necessary, emergency room physician shall include consultation with specialty physicians qualified to give an opinion or to render treatment necessary to stabilize the individual.

~~7.~~ 9. When transfer teams from the receiving facility are utilized, they assume responsibility for the patient on their arrival, as long as the patient's condition remains unchanged.

~~8.~~ 10. If the individual is transferred for non-medical reasons, the transferring physician will document that the transfer will not create deterioration or jeopardize the medical condition of the individual or unborn child.

~~9.~~ 11. When air or ground ACLS transport is required, physician orders for enroute transfer must be completed and signed by ~~M.D~~a physician~~medical provider~~. ~~On~~ on the appropriate forms.

~~10.~~ 12. Report by the RN responsible for the patient will be called to the RN receiving the patient at the accepting facility. This will include all hand off information (SBAR) and will include any current isolation procedures being followed and any pending cultures.

DOCUMENTATION:

1. Completion of emergent or non-emergent transfer form.
2. NIHD staff needs to document procedures done, IV infusions started and continuing for transfer, and/or medications given by the transport team while the patient remains at the hospital. This needs to be on the patient's medical record. As an option it is acceptable to get a copy of the transport ~~teams~~team's record to use for this documentation. In addition the RN should document any medications, IV infusions or supplies sent with the transport team.
3. Notation ~~in~~ by the nurse~~ing~~ within the record ~~of~~shall include:
    a. Time and method of transfer~~.~~
    b. Patient's condition on transfer including current V/S and cardiac rhythm when applicable~~.~~
    c. Disposition of belongings~~.~~
    d. Notification of family member if possible~~.~~
3. Completion of following forms for:
    a. Transfer to more appropriate facility for Medical Care (i.e., head injury)~~.~~
        1. Patient Transfer Acknowledgment: to be signed by the patient or his representative prior to transfer~~.~~
        2. Physician Certification Form: this is signed by the transferring physician to certify that the risks of transfer are outweighed by the ~~b~~Benefit of the ~~t~~Transfer~~.~~
    b. When the patient requests transfer to another facility (i.e. to be closer to home, or transfer is requested by an insurance company)~~.~~

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Transfer/Discharge to Another Facility	
Scope: ED and Inpatient Services	Manual: CPM – Admission, Discharge, Transfer (AI
Source: ~~Day Shift Nurse Supervisor~~CNO	Effective Date:

1. Patient Request for Transfer or Discharge: ~~Have~~ Ppatient or representative to sign this form~~.~~
2. Physician d~~D~~etermination t~~T~~ransfer for n~~N~~on-m~~M~~edical r~~R~~easons. To be completed by the physician for non-medical reason for transfer.
3. Physician f~~F~~orm: If the patient is being sent per their request for medical reasons. ~~(see 3 A 2 above).~~

c. When the patient refuses transfer:
   1. Have patient or legal representative sign the p~~P~~atient r~~R~~efusal of t~~T~~ransfer f~~F~~orm.

BOARD & CARE: ~~**(Sterling Heights is our local facility)**~~

1. Physician's Report - State of California Form completed by physician~~MD~~ needed for first time admission to facility only (Social Service has copies or the facility will provide).
2. Physician d~~D~~ischarge Instructions
3. Copy of ~~Current MAR~~ the current medication administration record (MAR) including last medications given~~(this will be a record of last dose of medication given prior to discharge)~~
4. Copy of f~~F~~ace s~~S~~heet
5. Copy of Advanced Directive/Power of Attorney/Living Will (if available)
6. New ~~residents~~resident's only---Current negative TB clearance or documented negative for TB chest X-ray.

SKILLED NURSING FACILITY (SNF):

1. Non e~~E~~mergent t~~T~~ransfer f~~F~~orm
2. PAS-PASARR - Document is completed by Social Services (may be completed by n~~N~~ursing s~~S~~upervisor if SS not available). Required for all Medi-Cal transfers to n~~N~~ursing h~~H~~omes and all transfers to Nevada n~~N~~ursing h~~H~~omes, regardless of insurance source
3. Copy of Advanced Directive/Power of Attorney/Living Will (if available).
4. Discharge/ t~~T~~ransfer s~~S~~ummary completed and if possible sent with patient at time of transfer (May need to fax if transfer completed prior to summary ready). ~~Bishop Care center requires,~~Some facilities may ask for this information prior to receiving the patient~~., discharge/transfer summary completed or completion of their Physician orders for skilled nursing forms.~~
5. Medical r~~R~~ecord c~~C~~hart c~~C~~opies.
6. Copy of the current medication administration record (MAR) including last medications given
   ~~a. Copy of Current MAR (this will be a record of last dose given and what medications patient has been on during hospitalization).~~
   ~~b.~~ a. Copy of Nutritional Screening~~.~~
   ~~c.~~ b. History and physical
   ~~d.~~ c. Consults.
   ~~e.~~ d. Current labs~~.~~
   ~~f.~~ e. X-ray r~~R~~eports (film copies not necessary unless requested)~~.~~
   ~~g.~~ f. Operative r~~R~~eport~~.~~
   ~~h.~~ g. Copy of f~~F~~ace s~~S~~heet~~.~~

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Transfer/Discharge to Another Facility	
Scope: ED and Inpatient Services	Manual: CPM – Admission, Discharge, Transfer (AI
Source: ~~Day Shift Nurse Supervisor~~CNO	Effective Date:

6. ~~7.~~ Skin a~~A~~ssessment - needed only if there is a skin breakdown, wound, or bruise. Include pictures of these wounds if taken on admit and also those taken at discharge

7. ~~8.~~ TB Clearance: Clear Chest X-ray or Neg PPD is required unless patient is returning to SNF (Nevada requires report to read "Clear for TB". California does not.)

Approval	Date
Clinical Consistency Oversight Committee (CCOC)	6/5/17
PeriPeds Committee	7/21/17
Med Services/ICU	7/27/17
Emergency Room Committee	7/20/17
MEC	8/8/17
Board of Directors	
Last Board of Director review	

Initiated:
Revised: 3/95; 3/98 JK, 1/09 jk, 9/12jk
Reviewed: 3/98; 9/2000; 03/2006 BSS, 4/28/09 jk
Last Board of Director review: 3/15/17
Index Listings: Form, Transfer of Emergent/.Non-Emergent; Transfer, Non-Emergent/Emergent to another Facility; Transfer, Patient to Other Medical Facility; Patient Transfer to Other Medical Facility; Transfers to Other Medical Facilities; Patient Transfer, Emergent/Non-Emergent

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Staff and Allied Health Professional Application Fee Processing*	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 2/15/2017

PURPOSE:

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

POLICY:

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

   A. Physicians/Licensed Independent Practitioners (LIPs):

   1. Full credentialing (e.g., Active Staff, Consulting Staff)
      a. $300.00 per application for appointment
      b. $100.00 per application for reappointment
   2. Telemedicine credentialing (as delineated by the Medical Staff bylaws)
      a. $100.00 per application for appointment
      b. $100.00 per application for reappointment
   3. Locum Tenens application for temporary privileges
      a. $300.00 per initial application*

      *Application fee may be reimbursed for locum tenens applicants

   ~~A.~~**B. Allied Health Professionals (AHPs):**

   1. All categories (e.g., NP, PA)
      a. $150.00 per application for appointment
      b. $75.00 per application for reappointment

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

PROCEDURE:

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

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

Receptionist in the front lobby will provide a receipt of payment for fees to Medical Staff Office personnel.

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

    - 90076-Provider Application Fees

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

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

REFERENCES:

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

Approval	Date
MEC	**08/08/201702/07/2017**
Board of Directors	**08/16/201702/15/2017**

Developed: 8/25/16
Reviewed:
Revised: 8/8/17 dp
Supersedes:

Responsibility for review and maintenance: Chief of Staff, Medical Staff Support Manager
Index Listings: Application Fees

Northern Inyo Healthcare District
One Team. One Goal. Your Health.

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

PEDIATRICS

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:
- Completed accredited residency training in Pediatrics.
- Board Certified/Board Eligible by the American Board of Pediatrics or equivalent.
- PALS/NALS required. STABLE preferred.

INPATIENT CORE PRIVILEGES

Request	
☐	• Admit, evaluate, diagnose, treat, perform H&P, and provide consultation to patients from birth to young adulthood (21 years of age) with acute and chronic disease including routine newborn care. • Attendance at delivery to assume care of newborns including stabilization and coordination of transfer of sick or premature infant. • Endotracheal intubation.

OUTPATIENT CORE PRIVILEGES

Request	
☐	• Assess, evaluate, stabilize and/or provide treatment to patients from birth to young adulthood (21 years of age) who presents to the outpatient pediatric clinic with any illness, condition, or symptom. • Evaluate, diagnose, perform H&P, consult, and provide non-surgical treatment to patients.

SPECIAL PRIVILEGES

- ☐ Arthrocentesis and joint injection
- ☐ Application of cast/splint
- ☐ Bladder catheterization
- ☐ Burn management, 1st and 2nd degree
- ☐ Cerumen impaction removal
- ☐ Circumcision with clamp
- ☐ Cryotherapy, skin
- ☐ Conscious sedation (requires tutorial and current ACLS certificate)
- ☐ Digital nerve/ring block anesthesia
- ☐ Drainage of subungual hematoma
- ☐ Frenulectomy
- ☐ Incision and drainage of abscess
- ☐ Insertion and management of chest tubes – emergent only
- ☐ Insertion/removal of implanted contraceptive device (e.g. Nexplanon)
- ☐ Intraosseous (IO) placement – emergent only
- ☐ Local anesthetic techniques
- ☐ Manage uncomplicated minor closed fractures and uncomplicated dislocations
- ☐ Microscopic examination (urine, vaginal wet mount and skin preparations)
- ☐ Nail removal
- ☐ Perform simple skin biopsy or excision
- ☐ Peripheral nerve blocks
- ☐ Ligation of extra digit
- ☐ Lumbar puncture – emergent only
- ☐ Preliminary EKG interpretation – emergent only
- ☐ Placement of anterior and posterior nasal hemostatic packing
- ☐ Remove non-penetrating foreign body from the skin, eye, nose or ear
- ☐ Skin tag – ligation
- ☐ Suture uncomplicated lacerations
- ☐ Suprapubic bladder tap – emergent only
- ☐ Tympanometry
- ☐ Umbilical catheterization – emergent only
- ☐ Uncomplicated wound debridement

CONSULTING PRIVILEGES
(for Consulting Staff only)

Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgement on next page.

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

_____ _____
Chief of Pediatrics *Date*

_____ _____
Chief of Surgery *Date*

_____ _____
Chief of Staff *Date*

_____ _____
President, Board of Directors *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

ORTHOPEDIC SURGERY

Instructions: Please check box next to each core privilege/special privilege requested.
Draw a line through and initial any core privilege not requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in Orthopedic Surgery.
- Board Certified/Board Eligible by the American Board of Orthopedic Surgery or equivalent.

CORE PRIVILEGES

Request	
☐	• Admit, evaluate, diagnose, consult, perform H&P, and provide nonsurgical and surgical care to correct or treat various conditions, illnesses or injuries of the musculoskeletal system in adults and children such as: – Trauma, including extremity fracture surgery – Hand and foot surgery – Athletic injuries, including arthroscopy – Orthopedic rehab, including amputations and post amputation care – MS imaging – Orthopedic oncology – Rehab of peripheral neurologic injury and disease – Orthotics and prosthetics – Cast application/splint – Joint aspiration, joint injection – Suture and wound care – Primary joint replacement – Shoulder/elbow surgery – Management of urgent and emergent pediatric orthopedic disease and injury – Non-operative sports medicine – Skin grafts

SPECIAL PRIVILEGES

☐ Complex and re-do joint replacement	☐ Microvascular flaps
☐ Conscious sedation (requires tutorial and ACLS certificate)	☐ Spinal surgery
	☐ Vascular grafts of the hands and forearm

CONSULTING PRIVILEGES
(for Consulting Staff only)

Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgment on next page.

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

_____ _____
Chief of Surgery *Date*

_____ _____
Chief of Staff *Date*

_____ _____
President, Board of Directors *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

GENERAL SURGERY

Instructions: Please check box next to each core privilege/special privilege requested.
Draw a line through and initial any core privilege not requested.

INITIAL CRITERIA	
Education/Formal Training: • Completed accredited residency training in General Surgery. • Board Certified/Board Eligible by the American Board of Surgery or equivalent.	
CORE PRIVILEGES	
Request	Admit, evaluate, diagnose, consult, perform H&P and provide nonsurgical and surgical pre-, intra-, and post-operative care on the ward and in the intensive care unit. Perform surgical procedures on adults and children including: Conditions, diseases, disorders and injuries of the head and neck, chest, abdomen and its contents, extremities, breast, skin and soft tissues and endocrine system.
☐	– Trauma – initial stabilization, resuscitation, emergency operative management of multiple trauma, burn and high-voltage electrical injuries. Staged and elective operations and coordination of specialty care of the injured patient. – Exposure, resection and/or repair of traumatic injuries involving the head and neck, thorax and intrathoracic components, abdominal cavity and extremities. – Tube thoracostomy, pericardiocentesis, tracheostomy, paracentesis, thoracentesis, bronchoscopy. – US guided vascular access, US-guided procedures and US of the breast – Mechanical ventilator management (invasive and non-invasive) – Arterial cannulation and pressure monitoring, Central venous pressure and Pulmonary artery catheter insertion, interpretation and monitoring – Breast/chest wall: biopsy, segmental resection; total, modified radical or radical mastectomies. Dissection of axillary lymph nodes, chest wall resection alone or in conjunction with breast procedure – Skin, soft tissue: Repair, excision and or grafting of injures or lesions involving the skin and subcutaneous tissues. Includes radical lymph node dissection, local or pedical flaps – Sentinel node mapping and biopsy for melanoma – Head and neck: biopsy and partial or complete resectional procedures involving the endocrine and exocrine glands, vascular, congenital and oncologic disorders – particularly tumors of the skin, salivary glands, thyroid and parathyroid. – Endocrine system including thyroid, parathyroid, adrenal and endocrine pancreas. – Abdomen operations on the: GI tract (esophagus, stomach, small bowel, colon, rectum, anus and biliary tract); other intra-abdominal or retroperitoneal organs (liver, spleen, adrenals, pancreas) and exposure of such for other disciplines. – Procedures involving the GU and reproductive system (kidneys, ureters, bladder, external genitalia, uterus, fallopian tubes, ovaries) – Procedures on the anus and rectum to include resection or ablation of tumors, drainage of abscesses, treatment of fistula, fissures, resection or obliteration(infrared coagulator or banding treatment) of hemorrhoids or anal stricture repair – Abdominal wall: repair of hernias with or without use of mesh. Repair of wound dehiscence and resection of masses. – Musculoskeletal: Fasciotomy and amputations – Basic laparoscopy including: diagnostic, laparoscopic appendectomy, laparoscopic cholecystectomy, hernia (all forms), small and large bowel resections, ostomy formation and takedown. – PEG placement – EGD and colonoscopy with biopsy, elevated mucosal resection/dissection, removal of foreign body – General pediatric surgery: Elective surgical management of common pediatric surgical problems such as

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	hernias, pyloric stenosis. Management of traumatic injuries. – Wound care including placement of wound vac and skin grafts

SPECIAL PRIVILEGES

☐ Breast surgery specific – Sentinel lymph node mapping and biopsy for breast cancer.	☐ Focused Assessment with Sonography for Trauma exam (FAST)
☐ Conscious sedation (requires tutorial and ACLS)	☐ Introduction of radiologic contrast materials in conjunction with operative procedure or assessment of trauma or other anatomic problems (requires fluoroscopy license)
☐ Colorectal specific: Endorectal Ultrasound, Sacral Nerve Stimulator placement, sphincteroplasty; anal sphincter botox injection, repair of rectal prolapse (transabdominal and transperineal approaches)	☐ Lumbar puncture
☐ EGD with banding of varices	☐ Robotics (see separate list)

CONSULTING PRIVILEGES
(for Consulting Staff only)

Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

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(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

_____ _____
Chief of Surgery *Date*

_____ _____
Chief of Staff *Date*

_____ _____
President, Board of Directors *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

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Pediatric Critical Indicators

2017

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

Approved:

Peri-Peds Committee: 7/21/2017

MEC: 8/8/2017

BOD: 8/16/2017