Northern Inyo Hospital

May 16 2018 Regular Meeting

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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

May 16, 2018 at 5:30 p.m.

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

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each).*
3. New Business
   - A. Ad Hoc Committee report and Election of Board Member for District Zone 3 (*action item*).
   - B. Chief Executive Officer report (*information item*).
   - C. Medical Student housing (*information item*).
   - D. Gap in access to care (*information item*).
   - E. Bi-annual review of District Conflict of Interest Code (*action item*).
   - F. Quarterly Compliance report (*information item*).
   - G. Chief Operating Officer report (*information item*).
   - H. Chief Human Resources Officer report (*information item*).
   - I. Policy and Procedure approval, *Hospital Account*s (*action item*).
   - J. Chief Nursing Officer report (*information item*).
   - K. Inyo County First Five Childbirth Education and Breastfeeding Support Services Agreement (*action item*).
   - L. De-Escalation Team Policy and Procedure and Form (*action item*).
   - M. Chief Financial Officer report (*information item*).
   - N. Adoption of District Values (*action item*).
   - O. Board of Directors Policy and Procedure approvals (*action items*):
     1. *Use by NIHD Directors of District Email Accounts*
     2. *Appointments to the NIHD Board of Directors*
     3. *Compensation of the Chief Executive Officer*
     4. *Requests For Public Funds, Community Grants, Sponsorships*
     5. *Authority of the Chief Executive Officer for Contracts and Bidding*

6. *Officers and Committees of the Board of Directors*
7. *Public Records Requests*
8. *Northern Inyo Healthcare District Board of Directors Conflicts of Interest*
9. *NIHD Board Meeting Minutes*

4. Old Business

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

Consent Agenda (action items)

5. Approval of minutes of the April 12 2018 Special Meeting
6. Approval of minutes of the April 18 2018 Regular Meeting
7. Approval of minutes of the April 20 2018 Special Meeting
8. Financial and Statistical reports as of March 31 2018
9. 2013 CMS Survey Validation Monitoring
10. Policy and Procedure annual approvals

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

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

1. *Code Blue Procedure – Code Blue Team*
2. *Color-Coded Wristband Use*
3. *Evaluation and Medical Screening of Patients Presenting to the Emergency Department*
4. *Laser Safety*
5. *Leaving Hospital Against Medical Advice, Refusal of Treatment or Transfer*
6. *Management of the Behavioral Health Patient (5150 and non-5150)*
7. *Medical Screening Examination for Emergency Department Physician Assistant – Standardized Protocol*
8. *Medical Waste Management*
9. *Medication/Solution Transfer to the Sterile Field*
10. *Nursing Care Guidelines in the PACU*
11. *Preoperative Preparation and Teaching*
12. *Standards of Care PACU*

B. Annual Reviews (*action items*):

1. Surgical Critical Indicators 2018
2. Anesthesia Critical Indicators 2018
3. Perinatal Critical Indicators 2018
4. Neonatal Critical Indicators 2018 (*new*)

C. OB/GYN Core Privilege form update (*action item*).

D. Interim Chief of Radiology appointment (*action item*).

E. Medical Staff Appointments/Privileges (*action items*):

1. Steve N. Dong, MD (*Urology*) – Provisional Consulting Staff
2. Sheldon M. Kop, MD (*Radiology, Tahoe Carson Radiology*) – Consulting Staff
3. Ian K. Tseng, MD (*Teleradiology, Quality Nighthawk*) – Telemedicine Staff
4. Rainier A. Manzanilla, MD (*interventional cardiology*) – Provisional Consulting Staff

F. AHP Privileges (*action item*)

1. Jennifer Figueroa, PA-C – approval to function under the following standardized protocol: *Medical Screening Examination for Emergency Department Physician Assistant*

G. Telemedicine Staff Appointments/Privileges – Proxy Credentialing (*action item*):

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

- Zarmen Israelian, MD (*Endocrinolog*y) – Adventist Health, Telemedicine Staff

H. Medical Staff Resignation (*action item*):

- John Williamson, MD (*Renown Telecardiology*) – effective 1/19/18

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

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

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

C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 2 matters pending (*pursuant to Government Code Section*

54956.9).

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

14. Return to open session and report of any action taken in closed session.
15. 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.

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Compliance Report
May 2018

1. Comprehensive Compliance Program review
    a. As of May 2, 2018, >85% of the District's employee workforce have reviewed the Compliance Program.
    b. The Compliance Department has been following up individually with employee workforce members who have not read the assigned Compliance Program, since it is mandatory.
2. Breaches
    a. Calendar Year (CY) 2018 – (attachment A)
        i. 31 alleged breaches of PHI (Personal Health Information) potentially affecting 79 patients have been investigated by the Compliance Office
        ii. 15 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. CDPH has completed investigation of 10 cases. All 10 breaches were substantiated, but assigned no deficiency.
            2. Five (5) cases are still pending CDPH investigation.
3. Issues and Inquiries
    a. CY 2018 – More than 120 requests for research and input on a wide variety of topics have been made to the Compliance Department
    b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. (Conducting business with anyone on an exclusions list places NIHD at risk. It is considered fraud to bill any government payor for diagnostic or treatment claims, if ordered by an excluded provider.)
4. Audits
    a. Employee Access Audits (attachment B) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, "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.

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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.
- iii. Compliance performs between 300-500 audits monthly.
    1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.
- iv. Protenus has been selected to provide semi-automated auditing software services to NIHD beginning when we go live with Athena and partners.

b. 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.
- ii. We currently have around 100 Business Associates Agreements.

c. 340B – monitoring to ensure only processing approved providers and locations

d. HIPAA Security Risk Assessment
- i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.

5. Conflicts of Interest questionnaires
    a. Compliance has processed more than 560 Conflict of interest disclosure forms since January 1, 2018.
    b. The Management Plan form is being re-designed to simplify the process for our leadership team. (The reason we are at 71% of requested plans.)
    c. We are sending the Conflict of Interest Disclosure form to non-employee workforce this year. (Non-employee workforce members are typically physicians, members of the Board of Directors, student interns, etc.)
6. CPRA Requests
    a. The Compliance office has prepared documents for 1 CPRA request in CY 2018.
    b. This is a significant reduction in public records requests from the past several years.
7. Compliance Workplan (attachment C)
    a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud,

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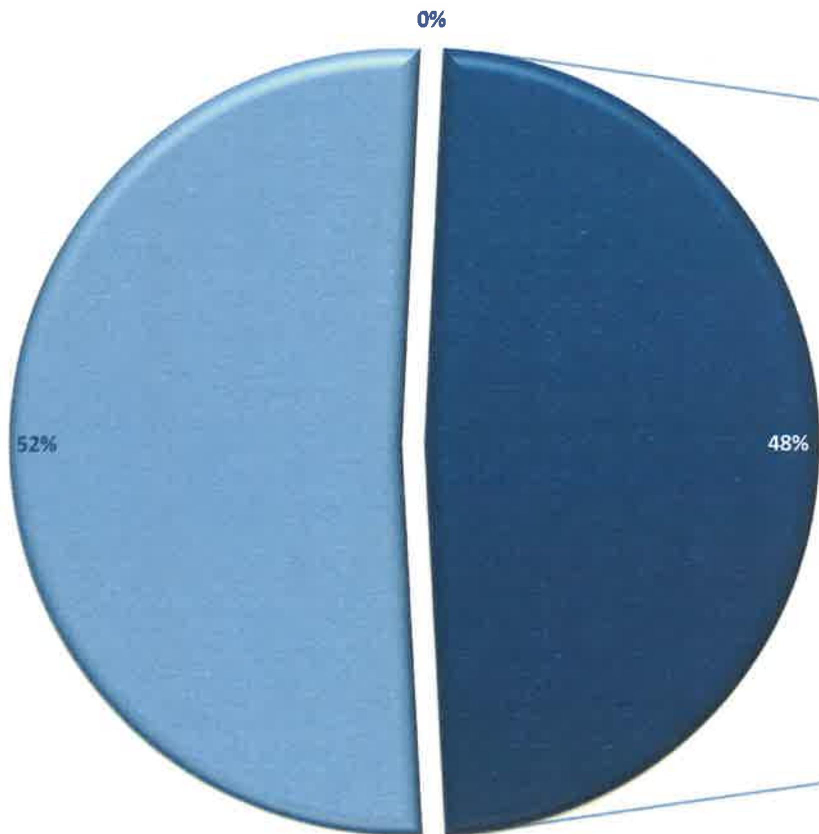
waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.

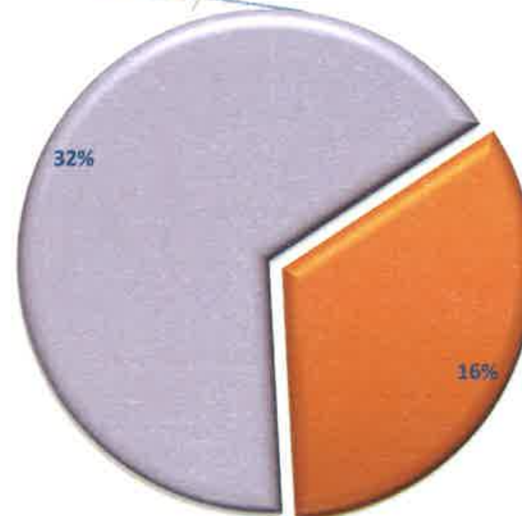
b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.

c. The attached workplan was approved by the Compliance and Business Ethics Committee in its April 2018 meeting.

2018 Breach Outcomes

15 Breach investigations potentially affecting 79 patients





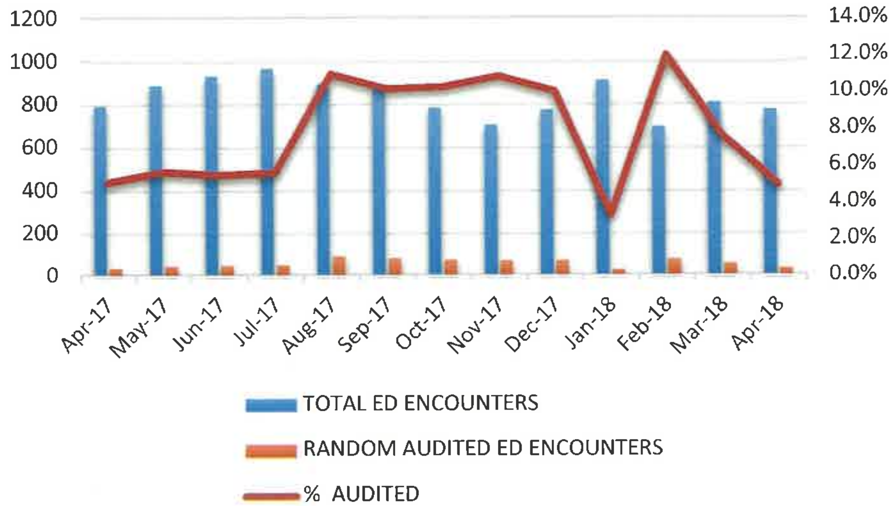
- Near-miss breach (no CDPH reporting)
- Reported to CDPH
- Reported, Unsubstantiated
- Substantiated, No Deficiency
- Deficiency, possible penalties
- Ongoing CDPH Investigation

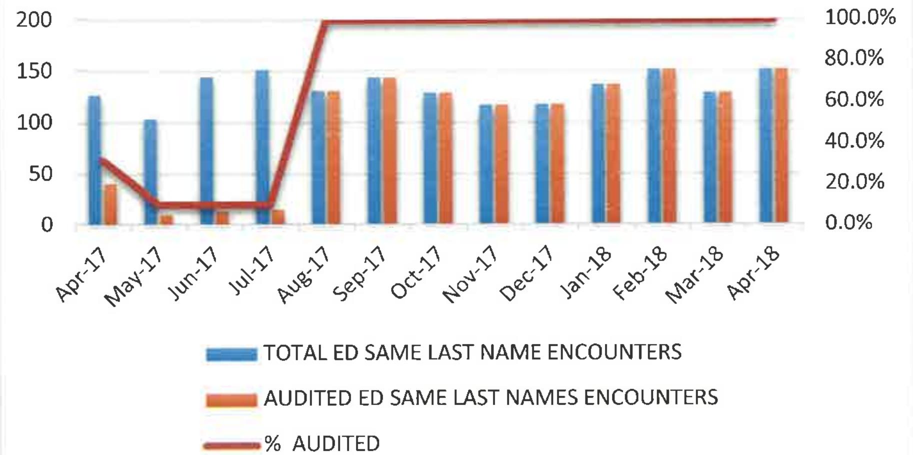
May 1, 2018

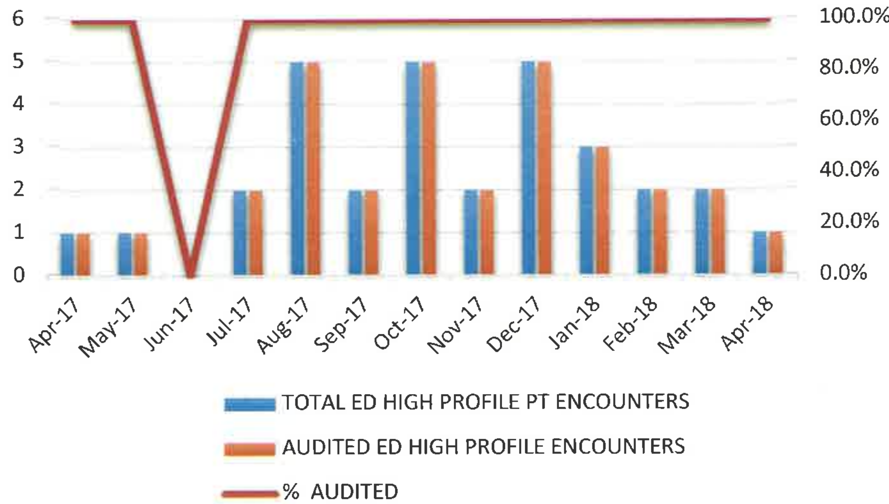
Attachment (A)

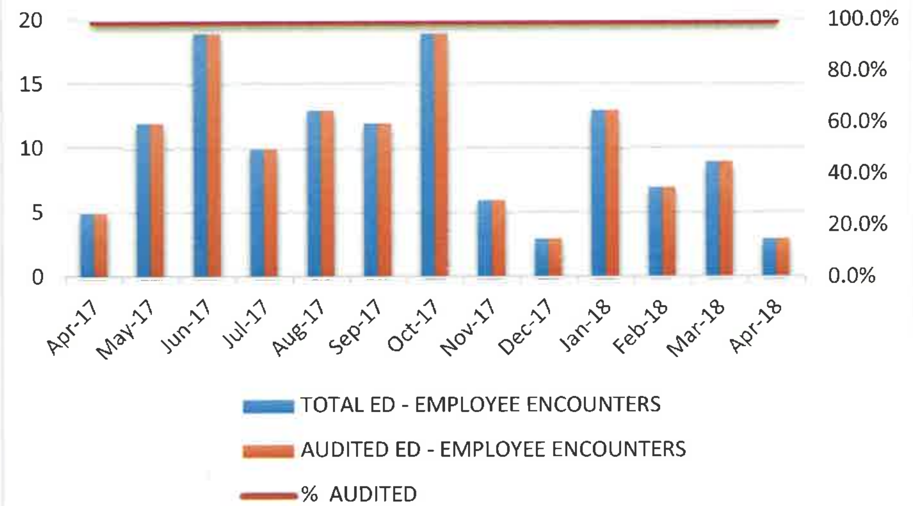
Employee EHR Access Audits

Emergency Room Encounters





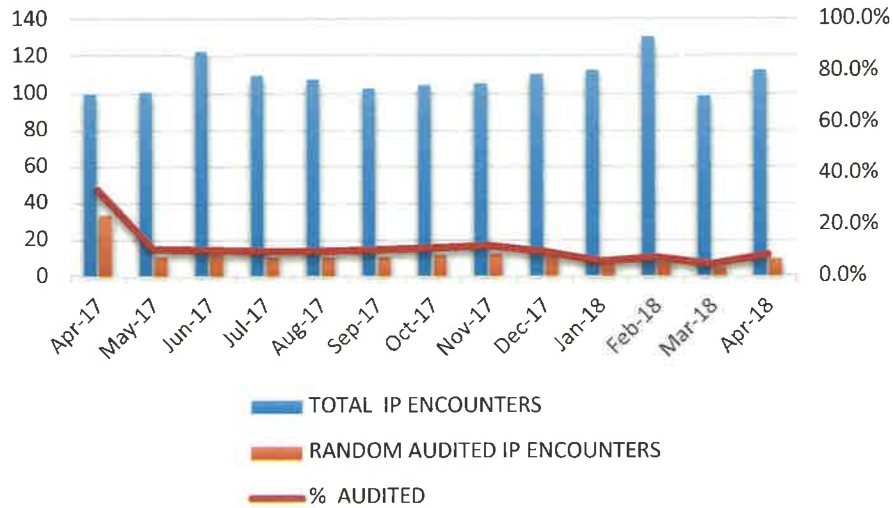


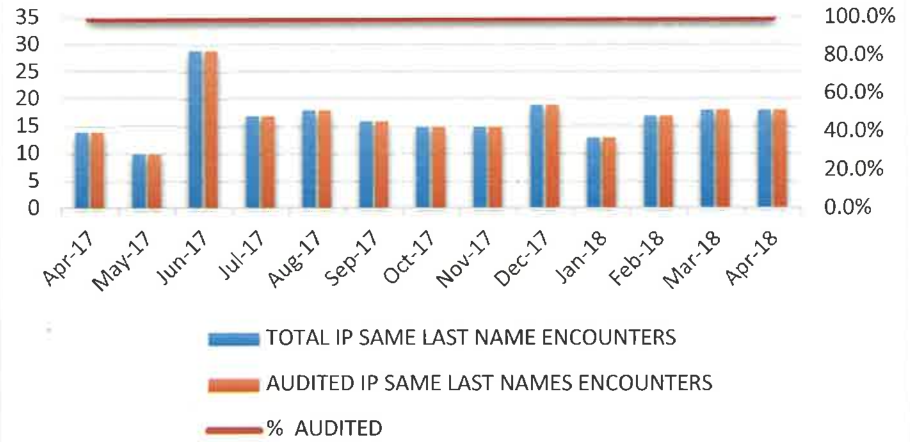


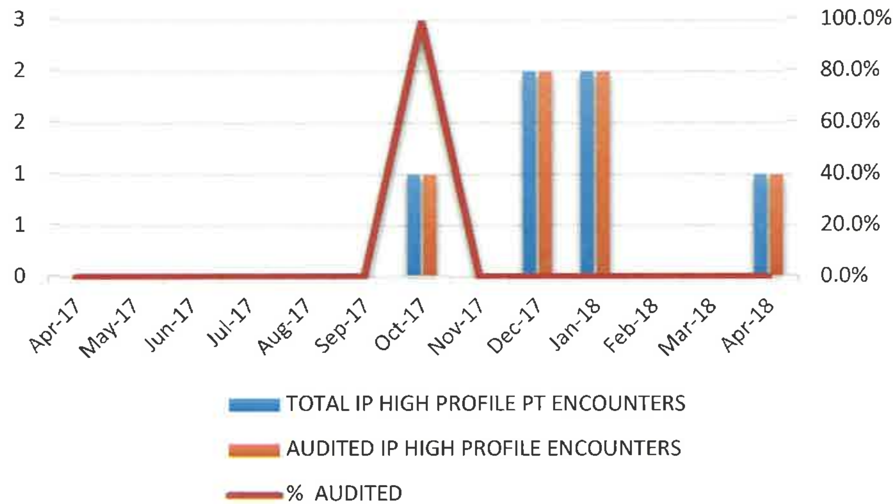
Attachment B.

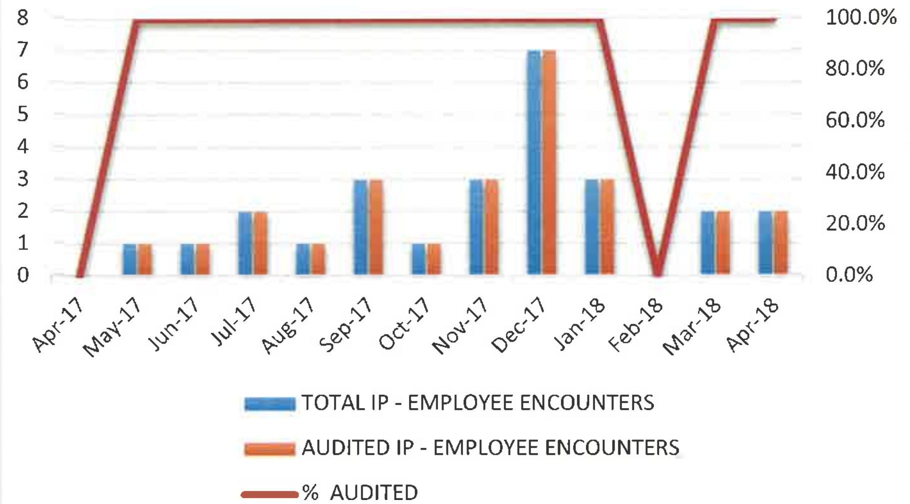
Employee EHR Access Audits

Inpatient Encounters









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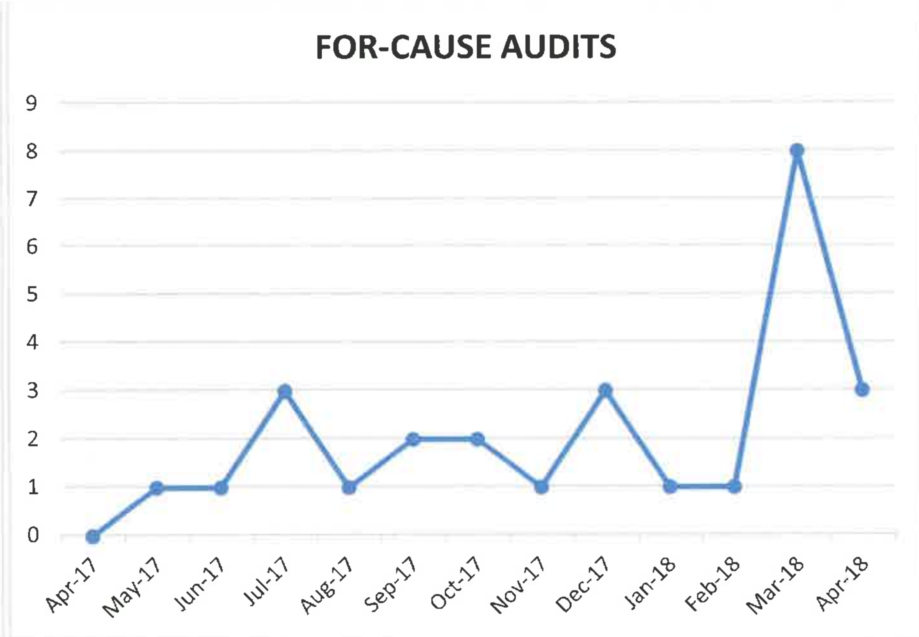
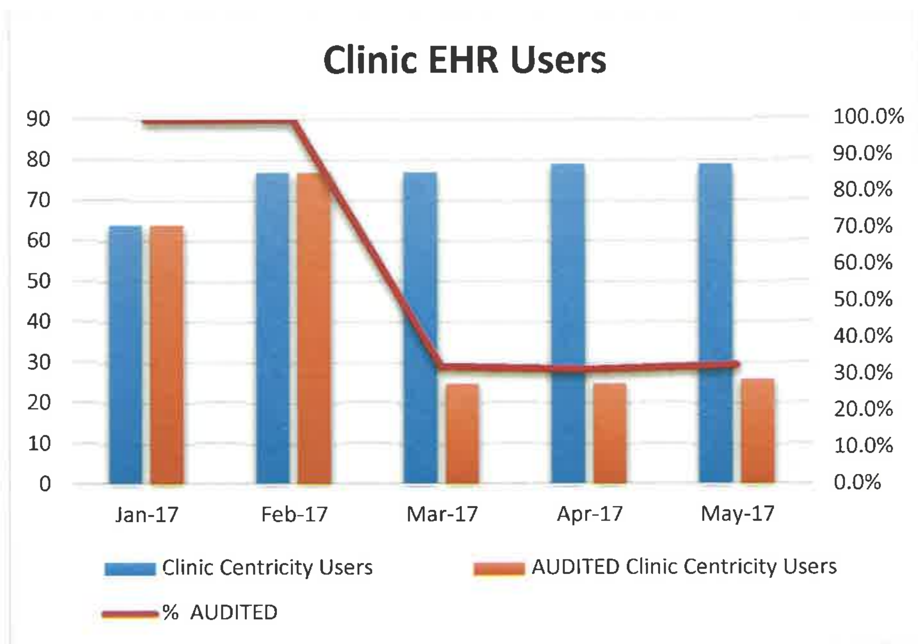
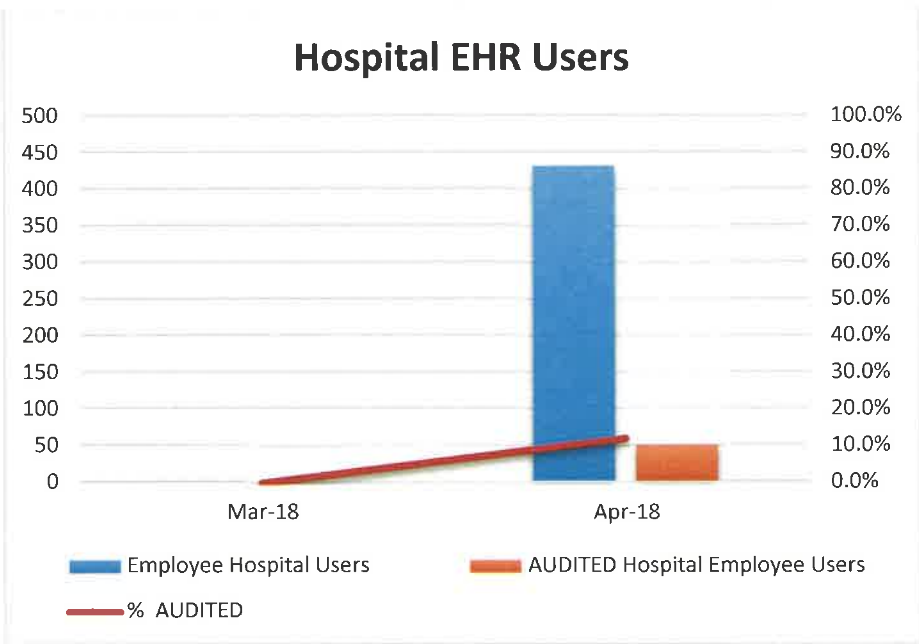
Employee EHR Access Audits







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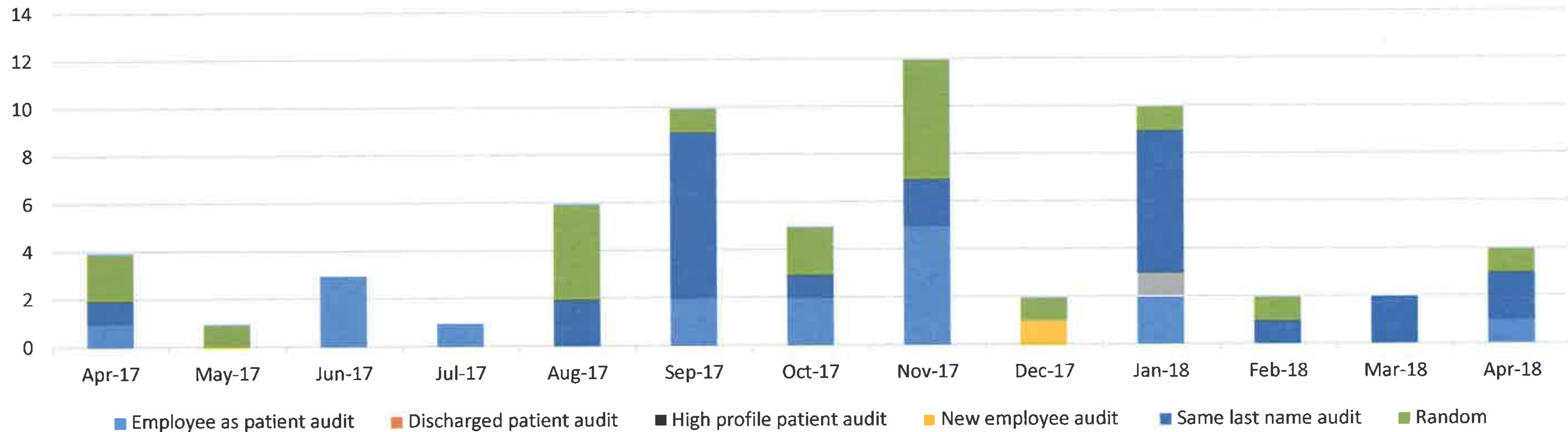
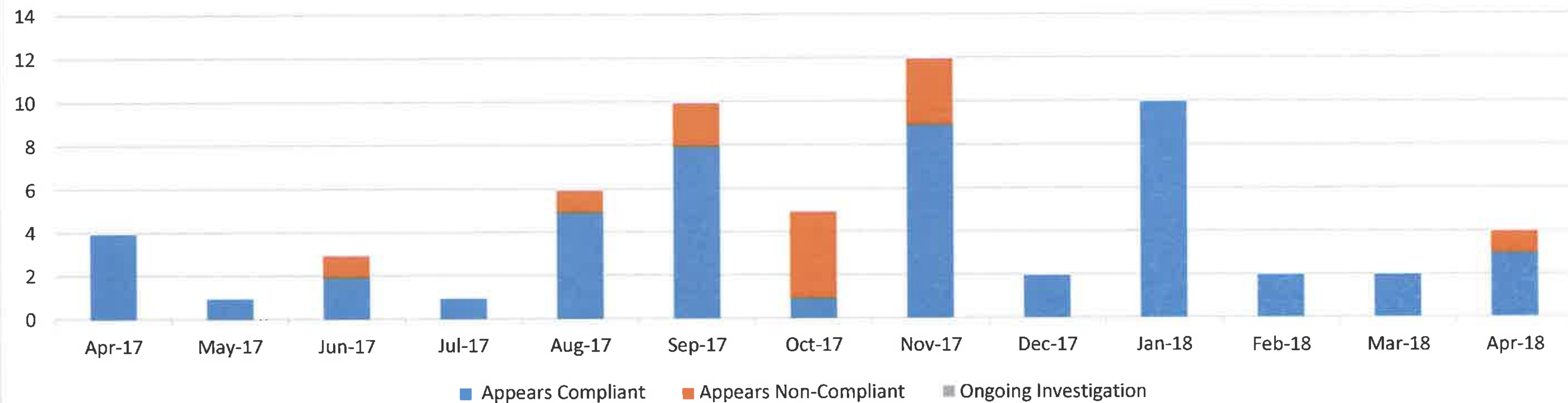
Employee EHR Access Audits





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Attachment C,

2018 Compliance Work Plan

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.		
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.		
Compliance Communication			
11.	Review investigation log. Prepare summary report for Compliance Committee on types of issues reported and resolution		
12.	Develop a report that evidences prompt documenting, processing, and resolution of		

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	complaints and allegations received by the Compliance Department.		
13.	Document test and review of Compliance Hotline.		
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.		
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		
Ongoing Compliance Monitoring and Auditing			
17.	Develop a compliance audit plan that addresses high-risk areas related to Federal healthcare program requirements and OIG compliance guidance.		
	a. Arrangements with physician (database)		
	b. EMTALA		
	c. Cost reports	Wipfli	
	d. Payment patterns		
	e. Bad debt/ credit balances		
	f. OPS – Home health and DME	HHS OIG target	
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		
	a. Annual Security Risk Assessment		
	b. Periodic update to SRA		
	c. Monthly employee access audits		
19.	Audit required signage		
20.	Audit HIMS scanned document accuracy		
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		
22.	Implement automated access monitoring/auditing software (Protenus)		
23.	Review CMS CoPs (CAH)		

C3

Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: De-escalation Team	
Scope: District-Wide	Manual: Clinical Practice Manual (CPM): Patient Safety
Source: Director of Nursing	Effective Date: DRAFT

PURPOSE:

To provide an expedient intervention response to situations involving individual(s) who display escalating, aggressive, hostile, violent, combative, or potentially dangerous behavior that exceed a workforce member's resources and require additional support to de-escalate.

POLICY:

1. The De-escalation Team will take responsibility and proactive measures for the safety and security of all individuals on hospital property by effectively responding to an escalating event and minimizing the number of potential harm and injuries.
2. Any De-escalation Team response should be in accordance with the procedure defined in this policy.
3. The De-escalation Team should be initiated for situations involving patients, visitors and/or other individuals exhibiting escalating, unarmed, violent, aggressive, and/or combative behavior. Situations involving active shooters and weapon violence require different response strategies. Follow the facilities protocol for reporting and addressing other situations.
4. Workforce members who are assigned to the De-escalation Team must have completed the training requirements in order to respond to the code. This code is not intended for all workforce members to respond.
5. This policy does not disallow any workforce member from contacting law enforcement. Any workforce member may seek assistance and intervention form law enforcement when a escalating and/or violent incident occurs.

Definitions:
De-escalation Team is a group of key individuals who are in-house or immediately available at the time of a request for the De-escalation Team and can quickly respond to the situation, notify internal leaders and law enforcement if required, and mitigate further harm. The team in collaboration with the Workplace Violence Prevention Assessment Team (V-PAT) to follow-up after the incident has occurred, further investigate the problem, and to create strategies to mitigate, communicate and provide support when needed.

The De-escalation Team Code is a response intended for a situation in which a patient, visitor, or other individual on hospital premises behaving in an aggressive, violent, combative, and/or potentially dangerous manner towards themselves, a workforce member, or others and indicates a potential for escalating or is escalating beyond a workforce member's resources. The Code responders use non-violent intervention strategies to defuse or regain control of a situation be using verbal de-escalation techniques or physical techniques that employ the lease restrictive measure possible.

Guidelines:
De-escalation Team Responders and their responsibilities include:

1. House Supervisor
    a. Can act as the Team Leader
    b. Excuses excess personnel when there are an adequate number of responders
    c. Assures unit safety and order is maintained
    d. Responsible for ensuring an informal debriefing session is held immediately following the incident for the team members and others involved in the event.
2. Social Worker (if available)
    a. Can act as a Team Leader
    b. Supports the workforce member with de-escalation techniques
    c. Can assist with Post Incident Response for workforce members
3. Emergency Department Charge Nurse

a. Supports the workforce member with de-escalation techniques
b. Assures the safety and security of the unit
c. Can act as the Team Leader

4. Security Personnel (if available)
   a. Takes immediate steps to assure safety of environment and workforce members
   b. Is positioned within close proximity to take immediate action, as necessary
   c. May assist with de-escalation
   d. Provides advice regarding need for involvement of Law Enforcement

During an intervention, there should be one and only one indentified person talking to the individual. There should be an agreed-upon plan and assigned duties for workforce members before a restraint or escort is initiated. All response team members should know their role and duties.

Training Requirements:

1. Workforce Members assigned to respond to a De-escalation Team Code, will receive education and training annually related to at least the following:
   a. Completion of Techniques for Effective Aggression Management training.
   b. Completion of a Health Stream Course(s) that include the following objectives:
      I. Aggression and violence predicting factors
      II. The assault cycle
      III. Characteristics of aggression and violent patients and victims
      IV. Verbal intervention and de-escalation techniques and physician maneuvers to defuse and prevent physical harm
   c. Appropriate use of therapeutic and behavioral restraints in alignment with the Patient Restraints Policy and Procedure.

PROCEDURE:

1. Escalating Behavior Levels for initiating the De-escalation Team:
   a. Threats and intimidation or refusing to follow instructions.
   b. Verbal or physical expressions of violence.
   c. Uncontrolled anger characterized by aggressive body postures and disposition.

2. INITIATING THE DE-ESCALATION TEAM CODE:
   a. As an individual escalates past the workforce member's resources to de-escalate and/or their behavior escalates the De-escalation Team will be called by a workforce member or designee, by dialing "71" and paging "De-escalation Team Code" to report to designated location.

3. WORKFORCE MEMBER RESPONSIBILITIES:
   a. The primary care nurse or workforce member who encounters or is caring for the escalating individual, take the following steps:
      I. Remain calm
      II. Provide details of the incident to the Team Leader including:
         A. Brief history of the incident
         B. Medical status
         C. Events leading to the current situation
         D. What action has been taken
         E. What action is believed to be required of the team
      III. Assist team as directed by the Team Leader.
      IV. Complete Workplace Violence Incident Report Form
   b. If a "De-escalation Team Code" is initiated in your area, take the following steps:
      I. If possible remove all individuals in immediate danger to a safe area
      II. Reduce noise producing equipment

III. Speak calmly
IV. Remove any loose equipment that could be used as a weapon or cause injury
V. The workforce member with the most knowledge of the individual or the situation will remain with the individual and report information to the Team Leader.

4. DE-ESCALATION TEAM RESPONDERS RESPONSIBILITIES:
   a. Report to scene of incident as quickly as possible
   b. The Team Leader role is assumed by:
      I. The first person on the scene, or
      II. A team member with confidence and competence in handling crisis situations, or
      III. A team member who has a rapport with the acting-out individual
   c. The Team Leader briefs the responders of the situation and coordinates the response and action plan.
      I. Possible incident action plan (IAP) objectives may include:
         A. Utilize de-escalation techniques
         B. Prevent harm and injury to self and other workforce members
   d. If the situation cannot be resolved using the De-escalation Team, contact Law Enforcement for assistance, if they have not yet been contacted or responded to the situation.
   e. Report any injuries immediately to Team Leader and refer personnel to obtain medical treatment and follow the Injury and Illness Prevention Program.
   f. Assure area is safe and secure for personnel and other patients to return.
   g. The Team Leader or designee, completes a De-escalation Team Code Response Form and attaches any pertinent documentation and submit the completed form to the Quality Assurance and Performance Improvement Department within one (1) business day.
   h. All personnel resume their normal duties.

5. POST INCIDENT RESPONSE
   a. In the event of a patient, family member and/or workforce member injury or at the request of the De-escalation Team, a Root Cause Analysis (RCA) and/or After Action Review (AAR) will be conducted by the Risk Manager or designee.
   b. Employee Assistance Program, defusing, crisis management briefing, critical incident stress debriefing, and/or other workforce member assistance programs will be offered to workforce members involved in the response, as appropriate.

REFERENCES:

1. California Occupations Safety and Health Standards Board (2016). *Section 3342. Workplace Violence Prevention in Health care*. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/workplace-violence-prevention-in-health-care-15day.pdf
2. Kelley, E. "Reducing Violence in the Emergency Department: A Rapid Response Team Approach." *Journal of Emergency Nursing* 2014; 40.1: 60-4.
3. Techniques for Effective Aggression Management Workbook, HSS (2017).

CROSS REFERENCE P&P:

Injury and Illness Prevention Program
Patient Restraints
Active Shooter

Approval	Date
V-PAT Team	04/13/2018
CCOC	04/23/2018

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Safety Committee	
Board of Directors	

Developed: 09/2016 MAG & AS
Revised: 05/18 MAG
Reviewed:
Supercedes:

Northern Inyo Healthcare
De-escalation Team Code Response Form

This form is to be filled out by the *De-escalation Team Leader* in collaboration with team members and staff involved in the code. This form is not part of the medical record and must not be copied. Once completed send the form to the Quality Assurance and Performance Improvement (QAPI) Department.

De-escalation Team called: Date:___/____/______ Time:____:____ AM PM Initiated By:______________
Incident Location: ____________________ Unit:__________________ Room:_________
Escalating Behavior By: ___Patient ___Staff ___Visitor Other ______________________
Escalating Behavior Directed Towards: ___Patient ___Staff ___Visitor Other ______________________

De-escalation Team arrived: Date:___/___/______ Time:____:____ AM PM
De-escalation Team Leader: ________________________________
De-escalation Team Members: ______________________________ ______________________________
______________________________ ______________________________

Behavior Levels Prompting Team/Code Page: (Please describe behaviors or quote defensive behavior)
____Intimidation ______________________________
____Offensive Language ______________________________
____Verbal Abuse ______________________________
____Verbal Assault ______________________________
____Physical Assault ______________________________

Behavior Levels Upon De-escalation Team Arrival: (please describe behaviors or quote defensive behavior)
____Escalating behavior (Challenging authority, hostile, beginning stage of loss of rationality)
____1. Questioning (challenging) ______________________________
____2. Refusal ______________________________
____3. Intimidation ______________________________
____4. Verbal Abuse ______________________________

____Verbally Acting Out ______________________________
____Physically Acting Out ______________________________

De-escalation Team Interventions:
____ Verbal Interventions: ______________________________
____ Release Inteventions:______________________________
____ Personal Safety Techniques:______________________________
____ Security Involvement ____ Required Law Enforcement Assistance
____ Other:______________________________

Disposition:
____ Stayed on Premises ____ Returned to room/unit ____ Escorted off Premises

Escalating Behavior Defused ___Yes ___No *If No, explain:* ______________________________
Clinical Debriefing Occurred ___Yes ___No
Workplace Violence Incident Report Completed? ___Yes ___No
What went right: ______________________________
What went wrong: ______________________________
Recommendation: ______________________________
____

NORTHERN INYO H~~OSPITAL~~EALTHCARE DISTRICT
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 15-03 HOSPITAL ACCOUNTS	
Scope: ~~Hospital~~ District Wide	Manual: Human ~~r~~Resources – Employee Handbook
Source: Human Resources	Effective Date: 11/20/2002

POLICY:

An employee who has an account with the ~~hospital~~ District may make arrangements with the Credit and Collections office for monthly payments of the account. If the employee wishes, the payments may be set up on a payroll deduction plan until the account is paid.

The payroll deduction amount will be in accordance with the payment terms offered to the general public and/or the residents of the ~~Northern Inyo HealthCare~~ District.

Approval	Date
~~Personnel/Payroll Advisory Committee~~	
Human Resources	
Administration	
Board of Directors	11/20/2002
Last Board of Director review	~~5/17/17~~5/16/2018
~~Last Board of Director review~~	~~5/17/17~~

University of Nevada, Reno
School of Medicine
Office of Medical Education

April 10, 2018

Mark K. Robinson, M.D. and Richard Meredick, M.D.
152A Pioneer Lane
Bishop, CA 93514-2556

Dear Drs. Robinson & Meredick,

Thank you so much for offering to continue sharing your knowledge, wisdom and practice with the UNR Med students in their MED 608 Advanced Experience in Rural Health Care clerkship next year. Your enthusiasm for teaching is very much appreciated!

It was great to meet many of you this year and we look forward to continuing to build on our relationship. If I didn't visit your site this year, I will make every effort to come visit you during the next clinical year beginning in September.

Based on the information you sent our office, we have tried to match students with their choices in both discipline and location. Therefore, the following fourth-year medical students have been assigned to you for the 2018-2019 Academic Year for the Rural Rotation:

Brian Wade, MS IV   Dec. 31 - Jan. 25, 2019

If for any reason, we have to change this schedule, we will contact you. And we hope you will let us know of any possible conflicts you may have during the timeslots you have offered. If you expect to be away for some of the times, the students are allowed to work with other clinicians in your practice at any time. Just let us know and we can work with you on this.

If you have shared your email address with us, you will receive an EVALUATION request with a link going directly to the One45 website, following the completion of the rotation. This past year, the LCME identified that our school has had too many evaluations completed over the 6 week limits and are looking for us to report this to them. We encourage you to complete the evaluation promptly as it helps you remember the student's performance immediately.

Again, we are very grateful for your participation in this part of the student's experience. The students have overwhelmingly valued the experience they received with you and your staff. They say that the rural experience has opened their eyes to the relationship and scope of practice you offer to your patients and community.

If you have any questions, please feel free to contact me directly at (775) 784-4886.

Sincerely,

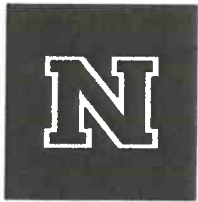
Nicole Preston, BGS
Administrative Assistant
Rural Medical Education

Patrick Enking, MS, PA-C, DFAAPA
Professor
Director of Rural Medical Education

cc: Kevin S. Flanigan, MD, CEO, Northern Inyo Hospital
Dianne Picken, Medical Staff Support Manager, Northern Inyo Hospital

RECEIVED
APR 17 2018
ADMINISTRATION OFFICE

Office of Medical Education • 1664 N. Virginia Street, MS 0342 • Reno, NV 89557 • (775) 784-6063 • fax (775) 784-6194 • http://med.unr.edu/ome



University of Nevada, Reno
School of Medicine
Office of Medical Education

April 9, 2018

Stacey L. Brown, M.D.
153-B Pioneer Lane
Bishop, CA 89423-4366

Dear Dr. Brown,

Thank you so much for offering to continue sharing your knowledge, wisdom and practice with the UNR Med students in their MED 608 Advanced Experience in Rural Health Care clerkship next year. Your enthusiasm for teaching is very much appreciated!

It was great to meet many of you this year and we look forward to continuing to build on our relationship. If I didn't visit your site this year, I will make every effort to come visit you during the next clinical year beginning in September.

Based on the information you sent our office, we have tried to match students with their choices in both discipline and location. Therefore, the following fourth-year medical students have been assigned to you for the 2018-2019 Academic Year for the Rural Rotation:

Christine Sjoquist, MS IV   Jan. 28 - Feb. 22, 2019

If for any reason, we have to change this schedule, we will contact you. And we hope you will let us know of any possible conflicts you may have during the timeslots you have offered. If you expect to be away for some of the times, the students are allowed to work with other clinicians in your practice at any time. Just let us know and we can work with you on this.

If you have shared your email address with us, you will receive an EVALUATION request with a link going directly to the One45 website, following the completion of the rotation. This past year, the LCME identified that our school has had too many evaluations completed over the 6 week limits and are looking for us to report this to them. We encourage you to complete the evaluation promptly as it helps you remember the student's performance immediately.

Again, we are very grateful for your participation in this part of the student's experience. The students have overwhelmingly valued the experience they received with you and your staff. They say that the rural experience has opened their eyes to the relationship and scope of practice you offer to your patients and community.

If you have any questions, please feel free to contact me directly at (775) 784-4886.

Sincerely,

Nicole Preston, BGS
Administrative Assistant
Rural Medical Education

Patrick Enking, MS, PA-C, DFAAPA
Professor
Director of Rural Medical Education

cc: Kevin S. Flanigan, MD, CEO, Northern Inyo Hospital
Dianne Picken, Medical Staff Support Manager, Northern Inyo Hospital
Paul Connolly, RHC Director, Northern Inyo Hospital

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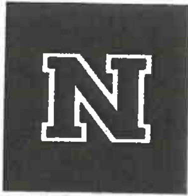

University of Nevada, Reno
School of Medicine
Office of Medical Education

April 10, 2018

Charlotte Helvie, M.D. and Louisa Salisbury, MD
Bishop Pediatrics & Allergy
152-H Pioneer Lane
Bishop, CA 96161-4835

Dear Drs. Helvie & Salisbury,

Thank you so much for offering to continue sharing your knowledge, wisdom and practice with the UNR Med students in their MED 608 Advanced Experience in Rural Health Care clerkship next year. Your enthusiasm for teaching is very much appreciated!

It was great to meet many of you this year and we look forward to continuing to build on our relationship. If I didn't visit your site this year, I will make every effort to come visit you during the next clinical year beginning in September.

Based on the information you sent our office, we have tried to match students with their choices in both discipline and location. Therefore, the following fourth-year medical students have been assigned to you for the 2018-2019 Academic Year for the Rural Rotation:

Matthew Shonnard, MS IV March 25 - April 19, 2019

If for any reason, we have to change this schedule, we will contact you. And we hope you will let us know of any possible conflicts you may have during the timeslots you have offered. If you expect to be away for some of the times, the students are allowed to work with other clinicians in your practice at any time. Just let us know and we can work with you on this.

If you have shared your email address with us, you will receive an EVALUATION request with a link going directly to the One45 website, following the completion of the rotation. This past year, the LCME identified that our school has had too many evaluations completed over the 6 week limits and are looking for us to report this to them. We encourage you to complete the evaluation promptly as it helps you remember the student's performance immediately.

Again, we are very grateful for your participation in this part of the student's experience. The students have overwhelmingly valued the experience they received with you and your staff. They say that the rural experience has opened their eyes to the relationship and scope of practice you offer to your patients and community.

If you have any questions, please feel free to contact me directly at (775) 784-4886.

Sincerely,

Nicole Preston, BGS
Administrative Assistant
Rural Medical Education

Patrick Enking, MS, PA-C, DFAAPA
Professor
Director of Rural Medical Education

cc: Kevin S. Flanigan, MD, CEO, Northern Inyo Hospital
Dianne Picken, Medical Staff Support Manager, Northern Inyo Hospital

RECEIVED
APR 17 20[illegible]
ADMINISTRATION OFFICE

Office of Medical Education • 1664 N. Virginia Street, MS 0342 • Reno, NV 89557 • (775) 784-6063 • fax (775) 784-6194 • http://med.unr.edu/ome

CONFLICT OF INTEREST CODE OF THE NORTHERN INYO HEALTHCARE DISTRICT COUNTY OF INYO, STATE OF CALIFORNIA

SECTION 1: Purpose

Pursuant to California Government Code section 87300, *et seq*., the Northern Inyo Healthcare District hereby adopts the following Conflict of Interest Code. Nothing contained herein is intended to modify or abridge the provisions of the *Political Reform Act of 1974* (California Government Code section 81000). The provisions of this Conflict of Interest Code are additional to California Government Code section 81700 and other laws pertaining to conflicts of interest. Except as otherwise indicated, the definitions of said Act and regulations adopted pursuant thereto are incorporated herein and this Conflict of Interest Code shall be interpreted in a manner consistent therewith.

SECTION 2: Designated Positions

The positions listed on Appendix "A" are designated positions. Persons holding these designated positions are designated positions and are deemed to make, or participate in the making of, decisions which may have a material effect on a financial interest.

SECTION 3: Disclosure Statements

Each designated position is assigned to one or more of the disclosure categories as set forth in Appendix "B". Each person in a designated position shall file a statement of financial interest disclosing that person's interest in investments, business positions, real property, and income, designated as reportable under the disclosure category to which the person's position is assigned on Appendix "A".

Notwithstanding the disclosure category to which a consultant position is assigned by Appendix "A", the Presiding Officer of the Northern Inyo Healthcare District's Governing Board may determine in writing that a particular consultant, although a "designated" position is hired to perform a range of duties that are limited in scope and, thus, is not required to fully comply with the disclosure requirements of the category designated for consultants on Appendix "A". Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent, if any, of the disclosure requirements for such consultant. Such written determination is a public record and shall be filed and retained for public inspection in the same manner and locations as is required for statements of financial interest.

SECTION 4: Place, Time, and Requirements of Filing

(A) Place of Filing.

All persons required to file a statement of financial interests shall file the original with the Inyo County Clerk, and a copy with the Presiding Officer of the Northern Inyo Healthcare District Governing Board.

(B) Time and Content of Filing.

The first statement by a person in a designated position upon the effective date of this Conflict of Interest Code shall be filed within thirty (30) days after the effective date of this Conflict of Interest Code, and shall disclose investments, business positions, and interest in real property held on the effective date of this Conflict of Interest Code and income received twelve (12) months before the effective date of this Conflict of Interest Code. The first statement by a person who assumes a designated position after the effective date of this Conflict of Interest Code shall be filed within thirty (30) days after assuming such position with the District and shall disclose investments, business positions, and interests in real property held, and income received, during the twelve (12) months before the date of assuming such position. After filing the first statement, each person in a designated position shall file an annual statement on or before April 1, disclosing reportable investments, business positions, interests in real property held, and income received, any time during the previous calendar year or since the date the person assumed the designated position during the calendar year. Every person in a designated position who leaves a designated position shall file, within thirty (30) days of leaving the position, a statement disclosing reportable investments, business positions, interests in real property held, and income received, at any time during the previous calendar year or since the date the person assumed the designated position during the calendar year. Every person in a designated position who leaves a designated position shall file, within thirty (30) days of leaving the position, a statement disclosing reportable investments, business positions, interests in real property held and income received, at any time during the period between the closing date of the last statement required to be filed, and the date of leaving the position.

SECTION 5: Contents of Disclosure Statement

Statements of financial interest shall be made on forms supplied by the Inyo County Clerk and shall contain all of the information as required by the current provisions of Government Code sections 87206 and 87207 for interest in investments, business positions, real property, and sources of income designated as reportable under the disclosure category to which the person's position is assigned on Appendix "A".

SECTION 6: Disqualification

A person in a designated position must disqualify himself or herself from making, or participating in the making, or using their official position to influence the making of any decision which will have a material financial effect, as distinguishable from its effect on the public generally, on any financial interest as defined in Section 87103 of the Government Code. No person in a designated position shall be required to disqualify himself or herself with respect to any matter which could not be legally acted upon or decided without his or her participation.

APPENDIX “A”
DESIGNATED POSITIONS

OF THE NORTHERN INYO HEALTHCARE DISTRICT
COUNTY OF INYO, STATE OF CALIFORNIA

DESIGNATED POSITIONS	DISCLOSURE CATEGORY
Members of the Board of Directors; Hospital Administrator/CEO; Chief Financial Officer/Chief of Fiscal Services; Chief Operating Officer	1
Chief Information Officer	2
Chief Human Relations Officer	2
Chief Nursing Officer	2
Director of Pharmacy	3
Director of Purchasing	3
Director of Laboratory	3
Director of Diagnostic Imaging	3
Dietary Director	3
Consultants, and Hospital District Legal Counsel	4

APPENDIX "B"
OF THE NORTHERN INYO HEALTHCARE DISTRICT

DISCLOSURE CATEGORIES

An investment, business position, interest in real property, or income is reportable if the business entity in which the investment or business position is held, the interest in real property, or the income or source of income may foreseeably be affected materially by any decision made or participated in by a person in a designated position.

Designated persons in Disclosure Category "1" must report:

All investments, interests in real property and income, any business entity in which the person is a director, officer, partner, trustee, employee, or holds any position of management, and any such business position. Financial interests are reportable only if located within or subject to the jurisdiction of the Northern Inyo Healthcare District or if the business entity is doing business or planning to do business in the jurisdiction or has done business within the jurisdiction at any time during the two years prior to the filing of the statement.

Designated persons in Disclosure Category "2" must report:

A. Investments in any business entity defined to be an "employer" or an "employment agency" within the meaning of the State Labor Statute.
B. Each source of income, provided that the income was furnished by or on behalf of any person defined to be an "employer, "labor organization", "employment agency, or "joint apprenticeship council" within the meaning of the California Labor Code.
C. His or her status as a director, officer, partner, trustee, employee, or any position of management in any business entity defined to be an "employer", "employment agency", labor organization", or "joint apprenticeship council", within the meaning of the State Labor Statute.

Designated persons in Disclosure Category "3" must report:

A. Investments in any business entity which, within the last two years, has contracted, or in the future foreseeably may contract with the Northern Inyo Healthcare District or with the State of California to provide services, supplies, materials, machinery or equipment to the department or division of the Healthcare District in which the persons serve as designated persons.

B. Income from any source which, within the last two years, has contracted, or in the future foreseeably may contract with the Healthcare District or with the State of California to provide services, supplies, materials, machinery or equipment to the department or division of the Healthcare District in which the persons serve as designated persons.
C. His or her status as director, officer, partner, trustee, employee, or holder of a position of management in any business entity, which, within the last two years, has contracted, or in the future foreseeably may contract with the Healthcare District or with the State of California to provide services, supplies, materials, machinery or equipment to the department or division of the Healthcare District in which the persons serve as designated persons.

Designated persons in Disclosure Category "4":

Are consultants. A consultant is any natural person who provides under contract information, advice, or recommendation of counsel to the Northern Inyo Healthcare District. The disclosure required of each consultant shall be determined on a case by case basis by the Hospital Administrator/CEO, based on whether the consultant participates in the making of decisions on behalf of the Northern Inyo Healthcare District which may foreseeably and materially affect any investments, interests in real property, or sources of income conceivably held by the consultant, or any business entity in which the consultant may conceivably hold a business position. The scope of disclosure required of each consultant, if any, shall be determined by the Hospital Administrator/CEO in writing in each case, and may include, but is not limited to, any source listed in Disclosure Categories 1, 2, or 3 or this Appendix.

This acknowledges that the Northern Inyo Healthcare District adopted this Conflict of Interest Code on Wednesday, August 17, 2016.

____

Signature of Authorized Officer
Denise Hayden, Governing Board President
Northern Inyo Healthcare District

Inyo County First 5 Grant Proposal
Beyond NEST
May 2018

NARRATIVE

Executive Summary

History, Mission, and Purpose

Northern Inyo Healthcare District (NIHD) is a 25 bed, Critical Access Hospital located in Bishop, California. It has been owned and operated by the Northern Inyo County Local Hospital District since its creation in 1946 under The Local Health Care District Law, Division 23, §32000 of the California Health and Safety Code. NIH has been accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) for over 40 years. NIH provides safety-net medical care to communities in Inyo and Mono counties, including Bishop, Wilkerson, Laws, Round Valley, 40 Acres, Big Pine, Paradise, Swall Meadows, Starlite, Aspendell, Mammoth Lakes, Benton, Hammill Valley, Chalfant, Independence, Lone Pine, Shoshone, Tecopa, as well as to visitors traveling through the region along highway 395 (the only connector between San Bernardino and Reno), and to several small communities in surrounding rural Nevada. The mission of Northern Inyo Healtcare District is "Improving our Communities one life at a time. One Team. One Goal. Your Health!" Northern Inyo Hospital's services include inpatient and outpatient services, 24-hour emergency services, ICU, orthopedic and general surgery, labor and delivery, pediatrics, family medicine, internal medicine, a Rural Health Clinic, radiology, laboratory, and physical therapy departments, among others. NIH has a state of the art, on-campus Imaging Center which offers and holds accreditations through the American College of Radiology for Magnetic Resonance Imaging, Mammography, Breast Magnetic Resonance Imaging, Ultrasound, Computed Tomography, and Nuclear Medicine. NIH is a contracted provider under Medicare, Medi-Cal and various commercial insurance programs, and also provides care to Charity Care patients in order to promote the public health and general welfare of the residents of northern Inyo County.

Past and Ongoing Organizational Accomplishments

Since establishment in 2015, the Newborn Evaluation Support & Teaching (NEST) Program has continued to provide evidence-based, best practices and education related to pregnancy preparation, labor, and breastfeeding support to local families. The NEST receives additional funding through grant awards from Inyo County First 5. During this time the NEST has continued and expanded its inpatient and outpatient services, including pre-admission visits, follow-up visits, Lactation Consults, as well as educational and support classes for the community. Additionally, the NEST continues to strive for the highest standards and has been recognized both internally and externally for its work in promoting and supporting breastfeeding and newborn care.

The California Breastfeeding Coalition awarded the NEST a Golden Nugget Award in 2015 for 'Breaking Down the Barrier of Lactation Problems.' As part of the award, the NEST was invited to host a table at the

California Breastfeeding Summit in 2015 to provide attendees with an overview of the NEST program and services.

In 2013, after receiving grant funding from First 5, the Perinatal Department began its journey to become a Baby Friendly accredited hospital. The Baby Friendly Hospital Initiative (BFHI) was started in 1991 by the World Health Organization (WHO) and UNICEF as a global initiative striving to protect, promote, and support breastfeeding. This credential is seen as the gold standard for maternity practices worldwide. In May of 2018, NIHD is excited to welcome the BFHI assessors on campus to audit our practices as well as our care providers, nurses, and patients, with the goal of obtaining BFHI designation.

Of the 50 counties in California, Inyo County was listed by the California WIC Association as having the 8th highest exclusive breastfeeding rate in 2015 with a rate of 86.7%. Because NIHD is the only hospital in Inyo County with the facilities to deliver babies, this ranking directly reflects the care and education we provide our Inyo County patients.

NEST's weekly Moms' Support Group facilitated by the NEST Lactation Consultant has been a resource for our postpartum patients not only for breastfeeding support but also as a source of consistent and reassuring support. The NEST works closely with the OB/GYN Clinic, Bishop Pediatric clinic, and Toiyabe Indian Health Clinic to ensure the Moms' Support Group is part of the plan of care for patients at risk or diagnosed with postpartum depression/anxiety. We have seen a surge in attendance this past year and have received positive feedback from our participants.

The NEST Childbirth classes, offered in both English and Spanish, have been well received and the pregnant mothers and their birth coaches report the comprehensive education prior to delivery greatly assists in preparation for childbirth and breastfeeding, as well as eases anxiety about the process. Additionally, the classes allow them to meet other families and expectant parents and form a cohort of support that carriers through into the postpartum Moms' Support Group. The NEST collaborates with the childbirth educator at Toiyabe Women, Infants, and Children (WIC) to ensure a childbirth class is offered to the community on a monthly basis, thereby increasing community pregnancy preparation. The NIHD classes have been offered as both one-day as well as multi-week sessions, thereby providing scheduling options and serving the various needs of our patients.

The NEST follows up with all delivered patients about their experience and breastfeeding practices. When completing these follow-up phone calls, the NEST routinely receives positive feedback from our patients, including statements such as "I never could have breastfed without the NEST," and "I wouldn't be breastfeeding now (at 3 months) if I didn't have the Moms' Support Group in those early days when everything felt so overwhelming." Receiving this type of feedback reinforces the important role the NEST plays in our community.

Project Goals & Outcomes

The NEST and NIHD are looking forward to ways to expand and improve our services for our community, specifically by increasing our breastfeeding rates, expanding NEST staffing, and increasing awareness of and access to educational and support services.

In an effort to further increase our rate of exclusively breastmilk-fed newborns, the NEST is seeking to establish a pasteurized Donor Breastmilk Program for high risk infants who have a medical indication to be supplemented. Approximately 17% of newborns delivered at NIHD require supplementation due to medical need during the first few days of life. Our current practice with these infants involves utilizing the mother's own breastmilk, and if that is not adequate, providing formula until the medical indication has resolved or mother's milk production has increased and can replace formula supplementation. The importance of feeding newborns solely breastmilk is reflected in the scientific studies that point to the increased risk in disease, illness and allergies with the introduction of even a small amount of formula during the first few days of life. Additionally, when supplementing with formula, even if medically indicated, the mother is more likely to continue supplementing with formula after the medical indication has resolved, thereby decreasing the maternal and infant benefits of exclusively breastfeeding as well as increasing the risk of early weaning. By implementing the Donor Breastmilk Program at NIHD, we would be able to provide our newborns with optimal nutrition, thereby increasing their health not only while they are young and vulnerable but also throughout their lives. Based on 2017 data, the Donor Breastmilk Program would potentially bring our rate of exclusively breastfed infants from 82% to 98%. NIHD would become the only hospital in the Eastern Sierra providing this exceptional service, and would join a group of progressive healthcare institutions providing optimal care for high risk newborns through a Donor Breastmilk Program. Implementing donor breastmilk programs is endorsed by the American Academy of Pediatrics, The World Health Organization, The Center for Disease Control and Prevention, Academy of Breastfeeding Medicine, Academy of OBGYN, Academy of Family Physicians, amongst other reputable organizations.

The next objective will be to expand the delivery of NEST services. This will be accomplished by the addition of a NEST shift for RNs with lactation training on Saturday and Sunday. Currently the NEST is staffed Monday through Friday by the two dedicated NEST RNs and Perinatal RNs work in the NEST on the weekends. These defined hours and staff during the week have improved patient access to breastfeeding support. However, on the weekend, because the Perinatal RNs are also expected to manage labor and delivery patients on the Perinatal Unit, they often are required to balance the one-on-one nature of a NEST appointment while also caring for patients on the floor. The new four hour weekend NEST shift will enable the same depth and quality of NEST visits on weekends as are provided during the week.

The next goal focuses upon improving access to our services, specifically our Childbirth Classes and Mom's Support Group. To achieve this, the NEST will research marketing strategies to promote these opportunities for our pregnant and postpartum patients. We wish to have more participants in our Spanish Childbirth Classes specifically and plan to utilize our Perinatal RN who is a Certified Lactation Educator and leads the Spanish Childbirth classes in outreach to the Hispanic community. We have flyers for these services throughout NIHD's campus as well as at Toiyabe WIC, Downtown WIC and First 5. Marketing through the

Inyo Register as well the local radio station are additional strategies we have not recently employed. Currently the Mom's Support Group meets at NIHD's facility located at Birch St. While this location is suitable, the NEST will research options to improve the comfort of the facility for our postpartum moms. We currently obtain breastfeeding statistics after discharge from the hospital through patient phone calls. During this time, we also strive to obtain information regarding barriers to breastfeeding in addition to any barriers to attending the Childbirth classes and Mom's Support Group. However, due to the difficulty in reaching our patients as well as the potential issue of honest feedback, we have found the follow-up phone calls to not be successful. We look forward to the implementation of NIHD's new computer system to improve capture of this information by the Pediatricians during Well Baby exams. This information will be invaluable for quality improvement of the NEST program.

Project Evaluation & Indicators

The key objectives this project seeks to achieve will be measured through data collection from the following areas:

- Increased exclusive breastfeeding rate upon discharge through Donor Breastmilk Program
- Increased participation and access to Childbirth classes, specifically the Spanish Childbirth Class
- Increased access to community support for breastfeeding through improved marketing of Moms' Support Group
- Increased respondent rate for data collection
- Collection of breastfeeding barriers
- mPINC scores
- Designation and maintenance as Baby Friendly Hospital

NEST will continue to utilize the NEST Pillars of Excellence to assess breastfeeding rates upon discharge and formula supplementation by maternal request or medical indication. The implementation of the Donor Breastmilk Program will enable parents to ensure their infants receive only breastmilk even if it is medically indicated to supplement.

NEST initiated childbirth classes in March of 2017. Since inception, 16% of mothers delivering at NID have gone through these classes, with only one mother attending the Spanish-language Childbirth class. As we continue to systematically measure the rate of mothers and their birth coaches attending childbirth classes prior to delivery, we will look for improvement at each of the program evaluation points including improved marketing. The participation in childbirth classes will be tracked at the time the patient is admitted to the Perinatal Unit through the admission assessment.

NEST offers a weekly Moms' Support Group that originally was rarely utilized by postpartum women. Participation increased in the Fall of 2017 with attendance varying each week. The participation in the support group will be tracked and reviewed by NEST staff.

The respondent rate for answering phone call surveys from NEST staff amongst discharged patients are low. Thus NEST relies heavily on the Pediatricians' charting during the infants' follow-up Well Baby appointments in the clinic. This data, however, is limited and not ideal for identifying what barriers exist to breastfeeding or other pertinent data beyond the infant's feeding type. The NEST believes that by modifying its data collection techniques by moving to an anonymous, online survey will address the current barrier it is facing gathering data from delivering mothers. At each program evaluation point the number of survey respondents will be compared against the deliveries during that period.

Lastly, due to its participation in the mPINC survey and with the potential designation as a Baby Friendly Hospital, NIH will know that is has fulfilled the Surgeon General's Call to Action to Support Breastfeeding, succeeded in implementing the BFHI's 10 Steps Successful Breastfeeding, and is providing the gold standard in maternity care.

Scope of Work

Initiate 4 hour NEST shift on Saturday and Sunday	May 2018
Baby Friendly accreditation survey	May 2018
Select 1 employee to complete IBCLC training	July 2018
Select 2 employees to complete Lactation Educator training	July 2018
Childbirth classes to be held bi-monthly. Format will rotate between weekend one-day sessions and multi-week evening sessions	Ongoing through life of project
Weekly Moms' Support Group	Ongoing through life of project
Provide Halo sleep sacks and safe sleep education to all patients	Ongoing through life of project
Participation in World Breastfeeding Month (table at Breastfeeding Walk)	August 2018 and annually
Quarterly report of NEST data	Quarterly
Development of new data collection methods (will be captured in new Electronic Health Record)	September 2018
Develop outreach and marketing material for Moms' Support Group	November 2018
Develop outreach and marketing material for Childbirth classes	November 2018
Implement Donor Breastmilk Program (Staff education, patient education and program initiation)	January 2019
Review NEST Gift bag contents and update	February 2019
California Breastfeeding Coalition Conference attendance- 2	February 2019 and annually

attendees	
Research, develop and implement improved Safe Sleep educational program	April 2019
Select 1 employee to complete IBCLC training	July 2019
Select 2 employees to complete Lactation Educator training	July 2019
Anticipated BFHI Renewal	July 2019 and annually
Select 1 employee to complete Childbirth Educator Training	July 2019
Select 1 employee to complete IBCLC training	July 2020
Select 2 employees to complete Lactation Educator training	July 2020
Select 1 employee to complete Childbirth Educator Training	July 2020
International Lactation Consultant Association Conference- 1 attendee	July 2020

AGREEMENT BETWEEN COUNTY OF INYO
AND Northern Inyo Hospital
FOR THE PROVISION OF Childbirth Education and Breastfeeding Support **SERVICES**

INTRODUCTION

WHEREAS, the County of Inyo (hereinafter referred to as "County") may have the need for the Prenatal Education services of Northern Inyo Hospital of Bishop, CA (hereinafter referred to as "Contractor"), and in consideration of the mutual promises, covenants, terms, and conditions hereinafter contained, the parties hereby agree as follows:

TERMS AND CONDITIONS

1. SCOPE OF WORK.

The Contractor shall furnish to the County, upon its request, those services and work set forth in Attachment **A,** attached hereto and by reference incorporated herein. Requests by the County to the Contractor to perform under this Agreement will be made by Marilyn Mann, whose title is: Health & Human Services Director. Requests to the Contractor for work or services to be performed under this Agreement will be based upon the County's need for such services. The County makes no guarantee or warranty, of any nature, that any minimum level or amount of services or work will be requested of the Contractor by the County under this Agreement. County by this Agreement incurs no obligation or requirement to request from Contractor the performance of any services or work at all, even if County should have some need for such services or work during the term of this Agreement.

Services and work provided by the Contractor at the County's request under this Agreement will be performed in a manner consistent with the requirements and standards established by applicable federal, state, and County laws, ordinances, regulations, and resolutions. Such laws, ordinances, regulations, and resolutions include, but are not limited to, those which are referred to in this Agreement.

2. TERM.

The term of this Agreement shall be from July 1, 2018 to June 30, 2021 unless sooner terminated as provided below.

3. CONSIDERATION.

A. Compensation. County shall pay to Contractor in accordance with the Schedule of Fees (set forth as Attachment **B)** for the services and work described in Attachment **A** which are performed by Contractor at the County's request.

B. Travel and per diem. Contractor will not be paid or reimbursed for travel expenses or per diem which Contractor incurs in providing services and work requested by County under this Agreement.

C. No additional consideration. Except as expressly provided in this Agreement, Contractor shall not be entitled to, nor receive, from County, any additional consideration, compensation, salary, wages, or other type of remuneration for services rendered under this Agreement. Specifically, Contractor shall not be entitled, by virtue of this Agreement, to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

D. Limit upon amount payable under Agreement. The total sum of all payments made by the County to Contractor for services and work performed under this Agreement shall not exceed Seventy-Two Thousand ($72,000.00) Dollars (hereinafter referred to as "contract limit"). County expressly reserves the right to deny any payment or reimbursement requested by Contractor for services or work performed which is in excess of the contract limit.

E. Billing and payment. Contractor shall submit to the County, once a month, an itemized statement of all services and work described in Attachment **A**, which were done at the County's request. This statement will be submitted to the County not later than the fifth (5th) day of the month. The statement to be submitted will cover the period from the first (1st) day of the preceding month through and including the last day of the preceding month. This statement will identify the date on which the services and work were performed and describe the nature of the services and work which were performed on each day. Upon timely receipt of the statement by the fifth (5th) day of the month, County shall make payment to Contractor on the last day of the month.

F. Federal and State taxes.

(1) Except as provided in subparagraph (2) below, County will not withhold any federal or state income taxes or social security from any payments made by County to Contractor under the terms and conditions of this Agreement.

(2) County will withhold California State income taxes from payments made under this Agreement to non-California resident independent contractors when it is anticipated that total annual payments to Contractor under this Agreement will exceed one thousand four hundred ninety nine dollars ($1,499.00).

(3) Except as set forth above, County has no obligation to withhold any taxes or payments from sums paid by County to Contractor under this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Contractor. County has no responsibility or liability for payment of Contractor's taxes or assessments.

(4) The total amounts paid by County to Contractor, and taxes withheld from payments to non-California residents, if any, will be reported annually to the Internal Revenue Service and the California State Franchise Tax Board. To facilitate this reporting, Contractor shall complete and submit to the County an Internal Revenue Service (IRS) Form W-9 upon executing this Agreement.

4. WORK SCHEDULE.

Contractor's obligation is to perform, in a timely manner, those services and work identified in Attachment **A** which are requested by the County. It is understood by Contractor that the performance of these services and work will require a varied schedule. Contractor will arrange his/her own schedule, but will coordinate with County to ensure that all services and work requested by County under this Agreement will be performed within the time frame set forth by County.

5. REQUIRED LICENSES, CERTIFICATES, AND PERMITS.

A. Any licenses, certificates, or permits required by the federal, state, county, municipal governments, for contractor to provide the services and work described in Attachment A must be procured by Contractor and be valid at the time Contractor enters into this Agreement or as otherwise may be required. Further, during the term of this Agreement, Contractor must maintain such licenses, certificates, and permits in full force and effect. Licenses, certificates, and permits may include, but are not limited to, driver's licenses,

professional licenses or certificates, and business licenses. Such licenses, certificates, and permits will be procured and maintained in force by Contractor at no expense to the County. Contractor will provide County, upon execution of this Agreement, with evidence of current and valid licenses, certificates and permits which are required to perform the services identified in Attachment **A**. Where there is a dispute between Contractor and County as to what licenses, certificates, and permits are required to perform the services identified in Attachment **A**, County reserves the right to make such determinations for purposes of this Agreement.

B. Contractor warrants that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in covered transactions by any federal department or agency. Contractor also warrants that it is not suspended or debarred from receiving federal funds as listed in the List of Parties Excluded from Federal Procurement or Non-procurement Programs issued by the General Services Administration available at: http://www.sam.gov.

6. OFFICE SPACE, SUPPLIES, EQUIPMENT, ETC.

Contractor shall provide such office space, supplies, equipment, vehicles, reference materials, and telephone service as is necessary for Contractor to provide the services identified in Attachment **A** to this Agreement. County is not obligated to reimburse or pay Contractor, for any expense or cost incurred by Contractor in procuring or maintaining such items. Responsibility for the costs and expenses incurred by Contractor in providing and maintaining such items is the sole responsibility and obligation of Contractor.

7. COUNTY PROPERTY.

A. Personal Property of County. Any personal property such as, but not limited to, protective or safety devices, badges, identification cards, keys, etc. provided to Contractor by County pursuant to this Agreement are, and at the termination of this Agreement remain, the sole and exclusive property of County. Contractor will use reasonable care to protect, safeguard and maintain such items while they are in Contractor's possession. Contractor will be financially responsible for any loss or damage to such items, partial or total, which is the result of Contractor's negligence.

B. Products of Contractor's Work and Services. Any and all compositions, publications, plans, designs, specifications, blueprints, maps, formulas, processes, photographs, slides, video tapes, computer programs, computer disks, computer tapes, memory chips, soundtracks, audio recordings, films, audio-visual presentations, exhibits, reports, studies, works of art, inventions, patents, trademarks, copyrights, or intellectual properties of any kind which are created, produced, assembled, compiled by, or are the result, product, or manifestation of, Contractor's services or work under this Agreement are, and at the termination of this Agreement remain, the sole and exclusive property of the County. At the termination of the Agreement, Contractor will convey possession and title to all such properties to County.

8. WORKERS' COMPENSATION.

Contractor shall provide Statutory California Worker's Compensation coverage and Employer's Liability coverage for not less than $1,000,000 per occurrence for all employees engaged in services or operations under this Agreement. The County of Inyo, its agents, officers and employees shall be named as additional insured or a waiver of subrogation shall be provided.

9. INSURANCE.

For the duration of this Agreement Contractor shall procure and maintain insurance of the scope and amount specified in Attachment **C** and with the provisions specified in that attachment.

10. STATUS OF CONTRACTOR.

All acts of Contractor, its agents, officers, and employees, relating to the performance of this Agreement, shall be performed as independent contractors, and not as agents, officers, or employees of County. Contractor, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of County. Except as expressly provided in Attachment **A**, Contractor has no authority or responsibility to exercise any rights or power vested in the County. No agent, officer, or employee of the Contractor is to be considered an employee of County. It is understood by both Contractor and County that this Agreement shall not under any circumstances be construed or considered to create an employer-employee relationship or a joint venture. As an independent contractor:

A. Contractor shall determine the method, details, and means of performing the work and services to be provided by Contractor under this Agreement.

B. Contractor shall be responsible to County only for the requirements and results specified in this Agreement, and except as expressly provided in this Agreement, shall not be subjected to County's control with respect to the physical action or activities of Contractor in fulfillment of this Agreement.

C. Contractor, its agents, officers, and employees are, and at all times during the term of this Agreement shall, represent and conduct themselves as independent contractors, and not as employees of County.

11. DEFENSE AND INDEMNIFICATION.

Contractor shall defend, indemnify, and hold harmless County, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, resulting from, or in connection with, the performance of this Agreement by Contractor, or Contractor's agents, officers, or employees. Contractor's obligation to defend, indemnify, and hold the County, its agents, officers, and employees harmless applies to any actual or alleged personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use. Contractor's obligation under this paragraph extends to any claim, damage, loss, liability, expense, or other costs which is caused in whole or in part by any act or omission of the Contractor, its agents, employees, supplier, or any one directly or indirectly employed by any of them, or anyone for whose acts or omissions any of them may be liable.

Contractor's obligation to defend, indemnify, and hold the County, its agents, officers, and employees harmless under the provisions of this paragraph is not limited to, or restricted by, any requirement in this Agreement for Contractor to procure and maintain a policy of insurance.

To the extent permitted by law, County shall defend, indemnify, and hold harmless Contractor, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, or resulting from, the active negligence, or wrongful acts of County, its officers, or employees.

12. RECORDS AND AUDIT.

A. Records. Contractor shall prepare and maintain all records required by the various provisions of this Agreement, federal, state, county, municipal, ordinances, regulations, and directions. Contractor shall maintain these records for a minimum of four (4) years from the termination or completion of this Agreement. Contractor may fulfill its obligation to maintain records as required by this paragraph by substitute photographs, microphotographs, or other authentic reproduction of such records.

B. Inspections and Audits. Any authorized representative of County shall have access to any books, documents, papers, records, including, but not limited to, financial records of Contractor, which County determines to be pertinent to this Agreement, for the purposes of making audit, evaluation, examination, excerpts, and transcripts during the period such records are to be maintained by Contractor. Further, County has the right, at all reasonable times, to audit, inspect, or otherwise evaluate the work performed or being performed under this Agreement.

13. NONDISCRIMINATION.

During the performance of this Agreement, Contractor, its agents, officers, and employees shall not unlawfully discriminate in violation of any federal, state, or local law, against any employee, or applicant for employment, or person receiving services under this Agreement, because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. Contractor and its agents, officers, and employees shall comply with the provisions of the Fair Employment and Housing Act (Government Code section 12900, et seq.), and the applicable regulations promulgated thereunder in the California Code of Regulations. Contractor shall also abide by the Federal Civil Rights Act of 1964 (P.L. 88-352) and all amendments thereto, and all administrative rules and regulations issued pursuant to said act.

14. CANCELLATION.

This Agreement may be canceled by County without cause, and at will, for any reason by giving to Contractor thirty (30) days written notice of such intent to cancel. Contractor may cancel this Agreement without cause, and at will, for any reason whatsoever by giving thirty (30) days written notice of such intent to cancel to County.

15. ASSIGNMENT.

This is an agreement for the services of Contractor. County has relied upon the skills, knowledge, experience, and training of Contractor as an inducement to enter into this Agreement. Contractor shall not assign or subcontract this Agreement, or any part of it, without the express written consent of County. Further, Contractor shall not assign any monies due or to become due under this Agreement without the prior written consent of County.

16. DEFAULT.

If the Contractor abandons the work, or fails to proceed with the work and services requested by County in a timely manner, or fails in any way as required to conduct the work and services as required by County, County may declare the Contractor in default and terminate this Agreement upon five (5) days written notice to Contractor. Upon such termination by default, County will pay to Contractor all amounts owing to Contractor for services and work satisfactorily performed to the date of termination.

17. WAIVER OF DEFAULT.

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided in paragraph twenty-three (23) below.

18. CONFIDENTIALITY.

Contractor further agrees to comply with the various provisions of the federal, state, and county laws, regulations, and ordinances providing that information and records kept, maintained, or accessible by Contractor in the course of providing services and work under this Agreement, shall be privileged, restricted, or confidential. Contractor agrees to keep confidential all such information and records. Disclosure of such confidential, privileged, or protected information shall be made by Contractor only with the express written consent of the County. Any disclosure of confidential information by Contractor without the County's written consent is solely and exclusively the legal responsibility of Contractor in all respects.

Notwithstanding anything in the Agreement to the contrary, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 45, Code of Federal Regulations Section 205.50, the Health Insurance Portability and Accountability Act of 1996, and Sections 10850 and 14100.2 of the Welfare and Institutions Code, and regulations adopted pursuant thereto. For the purpose of this Agreement, all information, records, and data elements pertaining to beneficiaries shall be protected by the provider from unauthorized disclosure.

19. CONFLICTS.

Contractor agrees that it has no interest, and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the work and services under this Agreement.

20. POST AGREEMENT COVENANT.

Contractor agrees not to use any confidential, protected, or privileged information which is gained from the County in the course of providing services and work under this Agreement, for any personal benefit, gain, or enhancement. Further, Contractor agrees for a period of two years after the termination of this Agreement, not to seek or accept any employment with any entity, association, corporation, or person who, during the term of this Agreement, has had an adverse or conflicting interest with the County, or who has been an adverse party in litigation with the County, and concerning such, Contractor by virtue of this Agreement has gained access to the County's confidential, privileged, protected, or proprietary information.

21. SEVERABILITY.

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction, or if it is found in contravention of any federal, state, or county statute, ordinance, or regulation, the remaining provisions of this Agreement, or the application thereof, shall not be invalidated thereby, and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

22. FUNDING LIMITATION.

The ability of County to enter this Agreement is based upon available funding from various sources. In the event that such funding fails, is reduced, or is modified, from one or more sources, County has the option to cancel, reduce, or modify this Agreement, or any of its terms within ten (10) days of its notifying Contractor of the cancellation, reduction, or modification of available funding. Any reduction or modification of this Agreement made pursuant to this provision must comply with the requirements of paragraph twenty-three (23) (Amendment).

23. AMENDMENT.

This Agreement may be modified, amended, changed, added to, or subtracted from, by the mutual consent of the parties hereto, if such amendment or change is in written form and executed with the same formalities as this Agreement, and attached to the original Agreement to maintain continuity.

24. NOTICE.

Any notice, communication, amendments, additions, or deletions to this Agreement, including change of address of either party during the terms of this Agreement, which Contractor or County shall be required, or may desire, to make, shall be in writing and may be personally served, or sent by prepaid first class mail to, the respective parties as follows:

County of Inyo
First 5 Inyo County ______ Department
~~568 West Line Street~~ ______ Street
Bishop, CA 93514 ______ City and State

Contractor:
Northern Inyo Hospital ______ Name
150 Pioneer Lane ______ Street
Bishop, CA 93514 ______ City and State

25. ENTIRE AGREEMENT.

This Agreement contains the entire agreement of the parties, and no representations, inducements, promises, or agreements otherwise between the parties not embodied herein or incorporated herein by reference, shall be of any force or effect. Further, no term or provision hereof may be changed, waived, discharged, or terminated, unless the same be in writing executed by the parties hereto.

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AGREEMENT BETWEEN COUNTY OF INYO
AND Northern Inyo Hospital
FOR THE PROVISION OF Childbirth Education and Breastfeeding Support **SERVICES**

IN WITNESS THEREOF, THE PARTIES HERETO HAVE SET THEIR HANDS AND SEALS THIS ______ DAY OF ____________________, ________.

COUNTY OF INYO

By:________________________________

Dated: ________________________________

CONTRACTOR

By:________________________________
Signature

____
Print or Type Name

Dated:________________________________

APPROVED AS TO FORM AND LEGALITY:

County Counsel

APPROVED AS TO ACCOUNTING FORM:

____
County Auditor

APPROVED AS TO PERSONNEL REQUIREMENTS:

____
Personnel Services

APPROVED AS TO INSURANCE REQUIREMENTS:

____
County Risk Manager

ATTACHMENT A

AGREEMENT BETWEEN COUNTY OF INYO
AND Northern Inyo Hospital
FOR THE PROVISION OF Childbirth Education and Breastfeeding Support **SERVICES**

TERM:

FROM: July 1, 2018 **TO:** June 30, 2021

SCOPE OF WORK:

The Contractor shall provide birthing classes, breastfeeding support groups, and related services as detailed in the accompanying Scope of Work attachment incorporated into this contract (Pages 9a and 9b). Contractor shall complete the tasks listed in this plan no later than June 30, 2021. Contractor shall provide requested fiscal and evaluation reports at quarterly intervals to First 5 Inyo. The schedule of due dates can be found in Attachment B Schedule of Fees.

All publicity materials for the public produced pursuant to this agreement shall include "Funded by First 5 Inyo County" and or the First 5 Inyo County logo. The Contractor shall coordinate with First 5 Inyo to promote the regularly scheduled birth classes and breastfeeding support group meetings, and that flyers for related services are available to new and expectant parents in NEST and new parent kits.

The major services this contract addresses and the ways they are to be measured include:

- Number of mothers served by:
  - Birthing Classes
  - Pre-admission visits
  - Post-discharge visits
  - Follow-up NEST visits
  - Outpatient Lactation Consults
  - New Moms' Support Group
- Number of mothers receiving safe sleep information and education
- Breastfeeding rates at:
  - Discharge
  - Two months
  - Four months
  - Six months
- Number of infants receiving Donor Breastmilk after initiation
  - Percentage of all patients
  - Percentage of those infants requiring supplementation

The respondent rate for answering phone call surveys from NEST staff amongst discharged patients are low. Thus NEST relies heavily on the Pediatricians' charting during the infants' follow-up Well Baby appointments in the clinic. This data, however, is limited and not ideal for identifying what barriers exist to breastfeeding or other pertinent data beyond the infant's feeding type. The NEST believes that by modifying its data collection techniques by moving to an anonymous, online survey will address the current barrier it is facing gathering data from delivering mothers. At each program evaluation point the number of survey respondents will be compared against the deliveries during that period.

Lastly, due to its participation in the mPINC survey and with the potential designation as a Baby Friendly Hospital, NIH will know that is has fulfilled the Surgeon General's Call to Action to Support Breastfeeding, succeeded in implementing the BFHI's 10 Steps Successful Breastfeeding, and is providing the gold standard in maternity care.

Scope of Work

Initiate 4 hour NEST shift on Saturday and Sunday	May 2018
Baby Friendly accreditation survey	May 2018
Select 1 employee to complete IBCLC training	July 2018
Select 2 employees to complete Lactation Educator training	July 2018
Childbirth classes to be held bi-monthly. Format will rotate between weekend one-day sessions and multi-week evening sessions	Ongoing through life of project
Weekly Moms' Support Group	Ongoing through life of project
Provide Halo sleep sacks and safe sleep education to all patients	Ongoing through life of project
Participation in World Breastfeeding Month (table at Breastfeeding Walk)	August 2018 and annually
Quarterly report of NEST data	Quarterly
Development of new data collection methods (will be captured in new Electronic Health Record)	September 2018
Develop outreach and marketing material for Moms' Support Group	November 2018
Develop outreach and marketing material for Childbirth classes	November 2018
Implement Donor Breastmilk Program (Staff education, patient education and program initiation)	January 2019
Review NEST Gift bag contents and update	February 2019
California Breastfeeding Coalition Conference attendance- 2	February 2019 and annually

attendees	
Research, develop and implement improved Safe Sleep educational program	April 2019
Select 1 employee to complete IBCLC training	July 2019
Select 2 employees to complete Lactation Educator training	July 2019
Anticipated BFHI Renewal	July 2019 and annually
Select 1 employee to complete Childbirth Educator Training	July 2019
Select 1 employee to complete IBCLC training	July 2020
Select 2 employees to complete Lactation Educator training	July 2020
Select 1 employee to complete Childbirth Educator Training	July 2020
International Lactation Consultant Association Conference- 1 attendee	July 2020

ATTACHMENT B

AGREEMENT BETWEEN COUNTY OF INYO
AND Northern Inyo Hospital
FOR THE PROVISION OF Childbirth Education and Breastfeeding Support **SERVICES**

TERM:

FROM: July 1, 2018 **TO:** June 30, 2021

SCHEDULE OF FEES:

For services satisfactorily rendered, and upon receipt of quarterly invoices, the County agrees to compensate the Contractor for annual expenditures in an amount not to exceed $24,000, with the full contract expenditures incurred from July 1, 2018 to June 30, 2021 in an amount not to exceed $72,000.

Actual program and equipment costs are to be invoiced to First 5 Inyo County after service delivery on a quarterly basis, 30 days after the last day of the quarter, listed below. Indirect costs are not to exceed 15% of the total contracted amount. Expenditures should not deviate from the proposed budget categories by more than $2,500 without the express written permission of the First 5 Inyo Commission.

Notwithstanding paragraph 3 E, Billing and Payment, quarterly invoices with attached expenditure sheets, fiscal receipts, and related evaluation materials should be received by First 5 Inyo no later than 15 days after the due dates listed below.

In the event that invoices or evaluation materials are late, the First 5 Inyo Commission retains the right to withhold payment until satisfactory receipt and review of those materials has taken place. Habitual tardiness over two or more due dates in provision of such agreed invoices or evaluation data, is cause for the First 5 Inyo Commission to review this contract for reduction or cancelation.

Due Date:

Year 1	Year 2	Year 3
November 1, 2018	November 1, 2019	November 1, 2020
February 1, 2019	February 1, 2020	February 1, 2021
May 1, 2019	May 1, 2020	May 1, 2021
August 1, 2019	August 1, 2020	August 1, 2021

Grant Funding Request 2018-2019		Hospital In-Kind Funding 2018-2019	
General	Budget yearly-average	General	Budget yearly-average
Personnel		Personnel	
		Hourly wages to staff NEST 7 days a week	$121,539
Education		Education	
2 RNs to attent California Breastfeeding Summit in 2019	$950		
Certified Lactation Educator (2 employee)	$1,300		
Lactation Consultant certification (1 employee)	$1,000		
BFHI Staff Training online for new hires/providers/clinic staff	$500		
Supplies		Supplies	
Birth Prep ($10/person based on 225 deliveries per year)	$2,250	General medical supplies in NEST	$2,000
NEST gift Bag ($20/person based on 225 deliveries per year)	$4,500		
Prenatal Education kit ($12/person based on 225 deliveries per year)	$2,700		
Educational materials and supplies for Mom's Support Group	$1,500		
Travel		Travel	
Travel/room & board for CBS (2 attendees)	$2,000		
Misc		Misc	
Marketing	$1,500	Marketing	$1,000
Milk Bank Donor Breastmilk Program	$2,000		
Freezer for Donor breastmilk	$3,800		
BFUSA Annual Fee	$1,300		
Totals:	$24,000	Totals:	$124,539

Grant Funding Request 2019-2020		Hospital In-Kind Funding 2019-2020	
General	Budget yearly-average	General	Budget yearly-average
Personnel		Personnel	
		Hourly wages to staff NEST 7 days a week	$121,539
Education		Education	
2 RNs to attent California Breastfeeding Summit in 2020	$950		
Certified Lactation Educator (2 employee)	$1,300		
Lactation Consultant certification (1 employee)	$1,500		
Childbirth Educator trianing for 1 staff RN	$1,500		
BFHI Staff Training online for new hires/providers/clinic staff	$500		
Supplies		Supplies	
Birth Prep ($10/person based on 225 deliveries per year)	$2,250	General medical supplies in NEST	$2,000
NEST gift Bag ($20/person based on 225 deliveries per year)	$4,500		
New Moms' Support Group supplies and materials	$1,500		
Prenatal Education kit ($12/person based on 225 deliveries per year)	$2,700		
Travel		Travel	
Travel/room & board for CBS (2 attendees)	$2,000		
Misc		Misc	
Marketing	$1,500	marketing	$1,000
Milk Bank Donor Breastmilk Program	$2,500		
BFUSA Annual Fee	$1,300		
Totals:	$24,000	Totals:	$124,539

Grant Funding Request 2020-2021		Hospital In-Kind Funding 2020-2021	
General	Budget yearly-average	General	Budget yearly-average
Personnel		Personnel	
		Hourly wages to staff NEST 7 days a week	$121,539
Education		Education	
2 RNs to attent CA Breastfeeding Summit in 2019	$950		
1 RN to attend International Lactation Consultant Association (ILCA) Conference in 2020	$900		
Certified Lactation Educator (2 employee)	$1,300		
Lactation Consultant certification (1 employee)	$1,500		
Childbirth Educator trianing for 1 staff RN	$1,500		
BFHI Staff Training online for new hires/providers/clinic staff	$500		
Supplies		Supplies	
Birth Prep ($10/person based on 225 deliveries per year)	$2,250	General medical supplies in NEST	$2,000
NEST gift Bag ($20/person based on 225 deliveries per year)	$4,500		
Prenatal Education kit ($12/person based on 225 deliveries per year)	$2,700		
Travel		Travel	
Travel/room & board for ILCA Conference (1 attendee)	$2,000		
Travel/room & board for CBS (2 attendees)	$2,000		
Misc		Misc	
Marketing	$600	Marketing	$1,000
Milk Bank Donor Breastmilk Program	$2,000		
BFUSA Annual Fee	$1,300		
Totals:	$24,000	Totals:	$124,539

ATTACHMENT C
AGREEMENT BETWEEN COUNTY OF INYO
AND Northern Inyo Hospital

FOR THE PROVISION OF Childbirth Education and Breastfeeding Support **SERVICES**

TERM:

FROM: July 1, 2018 **TO:** June 30, 2021

SEE ATTACHED INSURANCE PROVISIONS

Specifications 2

Insurance Requirements for Professional Services

Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

MINIMUM SCOPE AND LIMIT OF INSURANCE

Coverage shall be at least as broad as:

1. **Commercial General Liability** (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis for bodily injury and property damage, including products-completed operations, personal injury and advertising injury, with limits no less than **$1,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.
2. **Automobile Liability:** Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than **$500,000** per accident for bodily injury and property damage.
3. **Workers' Compensation** insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$1,000,000** per accident for bodily injury or disease.

(Not required if consultant provides written verification it has no employees)

1. **Professional Liability** (Errors and Omissions) Insurance appropriates to the Consultant's profession, with limit no less than **$1,000,000** per occurrence.

If the Consultant maintains higher limits than the minimums shown above, the Entity requires and shall be entitled to coverage for the higher limits maintained by the Consultant. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the Entity.

Other Insurance Provisions

The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status

1. **The Entity, its officers, officials, employees, and volunteers are to be covered as additional insureds** on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the consultant including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Consultant's insurance (at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10 and CG 20 37 forms if later revisions used).

Other Insurance Provisions

The insurance policies are to contain, or be endorsed to contain, the following provisions:

Primary Coverage
For any claims related to this contract, the **Consultant's insurance coverage shall be primary** insurance as respects the Entity, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the Entity, its officers, officials, employees, or volunteers shall be excess of the Consultant's insurance and shall not contribute with it.

Notice of Cancellation
Each insurance policy required above shall state that **coverage shall not be canceled, except with notice to the Entity**.

Waiver of Subrogation
Consultant hereby grants to Entity a waiver of any right to subrogation which any insurer of said Consultant may acquire against the Entity by virtue of the payment of any loss under such insurance. Consultant agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the Entity has received a waiver of subrogation endorsement from the insurer.

Deductibles and Self-Insured Retentions
Any deductibles or self-insured retentions must be declared to and approved by the Entity. The Entity may require the Consultant to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

Acceptability of Insurers
Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to the Entity.

Claims Made Policies
If any of the required policies provide coverage on a claims-made basis:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
2. Insurance must be maintained and evidence of insurance must be provided ***for at least five (5) years after completion of the contract of work.***
3. If coverage is canceled or non-renewed, and not ***replaced with another claims-made policy form with a Retroactive Dat***e prior to the contract effective date, the Consultant must purchase "extended reporting" coverage for a minimum of ***five (5)*** years after completion of contract work.

Verification of Coverage
Consultant shall furnish the Entity with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by the Entity before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Consultant's obligation to provide them. The Entity reserves the right to require complete,

certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

Subcontractors

Consultant shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein.

Special Risks or Circumstances

Entity reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

Grant Funding Request 2020-2021		Hospital In-Kind Funding 2020-2021	
General	Budget yearly-average	General	Budget yearly-average
Personnel		Personnel	
		Hourly wages to staff NEST 7 days a week	$121,539
Education		Education	
2 RNs to attent CA Breastfeeding Summit in 2019	$950		
1 RN to attend International Lactation Consultant Association (ILCA) Conference in 2020	$900		
Certified Lactation Educator (2 employee)	$1,300		
Lactation Consultant certification (1 employee)	$1,500		
Childbirth Educator trianing for 1 staff RN	$1,500		
BFHI Staff Training online for new hires/providers/clinic staff	$500		
Supplies		Supplies	
Birth Prep ($10/person based on 225 deliveries per year)	$2,250	General medical supplies in NEST	$2,000
NEST gift Bag ($20/person based on 225 deliveries per year)	$4,500		
Prenatal Education kit ($12/person based on 225 deliveries per year)	$2,700		
Travel		Travel	
Travel/room & board for ILCA Conference (1 attendee)	$2,000		
Travel/room & board for CBS (2 attendees)	$2,000		
Misc		Misc	
Marketing	$600	Marketing	$1,000
Milk Bank Donor Breastmilk Program	$2,000		
BFUSA Annual Fee	$1,300		
Totals:	$24,000	Totals:	$124,539

Grant Funding Request 2019-2020		Hospital In-Kind Funding 2019-2020	
General	Budget yearly-average	General	Budget yearly-average
Personnel		Personnel	
		Hourly wages to staff NEST 7 days a week	$121,539
Education		Education	
2 RNs to attent California Breastfeeding Summit in 2020	$950		
Certified Lactation Educator (2 employee)	$1,300		
Lactation Consultant certification (1 employee)	$1,500		
Childbirth Educator trianing for 1 staff RN	$1,500		
BFHI Staff Training online for new hires/providers/clinic staff	$500		
Supplies		Supplies	
Birth Prep ($10/person based on 225 deliveries per year)	$2,250	General medical supplies in NEST	$2,000
NEST gift Bag ($20/person based on 225 deliveries per year)	$4,500		
New Moms' Support Group supplies and materials	$1,500		
Prenatal Education kit ($12/person based on 225 deliveries per year)	$2,700		
Travel		Travel	
Travel/room & board for CBS (2 attendees)	$2,000		
Misc		Misc	
Marketing	$1,500	marketing	$1,000
Milk Bank Donor Breastmilk Program	$2,500		
BFUSA Annual Fee	$1,300		
Totals:	$24,000	Totals:	$124,539

Grant Funding Request 2018-2019		Hospital In-Kind Funding 2018-2019	
General	Budget yearly-average	General	Budget yearly-average
Personnel		Personnel	
		Hourly wages to staff NEST 7 days a week	$121,539
Education		Education	
2 RNs to attent California Breastfeeding Summit in 2019	$950		
Certified Lactation Educator (2 employee)	$1,300		
Lactation Consultant certification (1 employee)	$1,000		
BFHI Staff Training online for new hires/providers/clinic staff	$500		
Supplies		Supplies	
Birth Prep ($10/person based on 225 deliveries per year)	$2,250	General medical supplies in NEST	$2,000
NEST gift Bag ($20/person based on 225 deliveries per year)	$4,500		
Prenatal Education kit ($12/person based on 225 deliveries per year)	$2,700		
Educational materials and supplies for Mom's Support Group	$1,500		
Travel		Travel	
Travel/room & board for CBS (2 attendees)	$2,000		
Misc		Misc	
Marketing	$1,500	Marketing	$1,000
Milk Bank Donor Breastmilk Program	$2,000		
Freezer for Donor breastmilk	$3,800		
BFUSA Annual Fee	$1,300		
Totals:	$24,000	Totals:	$124,539

NIHD BOARD OF DIRECTOR'S MISSION, VISION, AND VALUE STATEMENTS

MISSION STATEMENT

Strong stewardship. Ethical Oversight. Eternal local access.

VISION STATEMENT

To be an energized, high performing advocate for the communities we serve, our patients and our staff. The Board governs with an eye on the future of healthcare and its effects on the District and patient care. The Board is committed to continuous evaluation, dedication to our mission, and improvements as a Board.

VALUES

The members of Northern Inyo Healthcare District Board of Directors are guided by these values in fulfilling our mission and achieving our vision.

- **INTEGRITY -** We believe in maintaining the highest standards of behavior encompassing honesty, ethics, loyalty, and doing the right thing for the right reason.
- **INNOVATIVE VISION -** We strive to be capable of extraordinary creativity and are willing to explore new approaches to improving quality of life for all persons.
- **STEWARDSHIP** – We are dedicated to be responsible stewards of our team, assets and financial resources, and to community service.
- **TEAMWORK** – We have an abiding respect for others, and a sustaining commitment to work together.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Appointments to the NIHD Board of Directors	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Procedures to fill a vacancy on the NIHD Board of Directors by appointment.

POLICY: When the Board of Directors (BOD) is notified of a vacancy or upcoming vacancy the BOD shall determine at a regular or special meeting whether to fill a vacancy by election or appointment. The following procedures shall apply if the BOD decides to fill the vacancy by appointment. Gov. Code 1780(a)

PROCEDURE:

1. The district shall notify the county elections official of the vacancy no later than 15 days following either the date on which the BOD is notified of the vacancy or the effective date of the vacancy, whichever is later.
2. The BOD must first post a notice of the vacancy in three or more conspicuous places in the district at least 15 days before the appointment is made.
3. Persons interested in the position shall submit an "Application for Appointment to a Special District Vacancy" and will be required to complete Form 700, "Statement of Economic Interests" form. Applications shall be available at the District Administration Office.
4. Interested persons shall acknowledge they will be subject to the District's Conflict of Interest Policy.
5. The BOD shall appoint an Ad Hoc committee of two board members to interview all applicants and bring a recommendation to the full BOD for consideration.
6. The district has 60 days from the date the BOD is notified of the vacancy or the effective date of the vacancy, whichever is later to fill the vacancy by appointment or call a special election. Gov. Code 1780. If necessary the BOD shall call a special meeting to make the appointment within the 60-day deadline.
7. The BOD must notify the county elections official of the appointment no later than 15 days after the appointment is made.
8. The appointed person shall hold office until the next November general election that is scheduled 130 or more days after the date the district board is notified of the vacancy, and thereafter until the person elected at that election to fill the vacancy has been qualified. The person elected to fill the vacancy shall fill the balance of the unexpired term. Gov. Code 1780(a)
9. If the term of office left vacant is due to expire following the next November general election and that election if scheduled 130 or more days after the date the county election official is notified of the vacancy, the person appointed to the vacancy shall fill the balance of the unexpired term of their predecessor.

REFERENCES:

1. Government Code 1780
2. County of Inyo Clerk/Recorder Office

CROSS REFERENCE P&P:

1.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Appointments to the NIHD Board of Directors	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

Approval	**Date**
Legal Counsel	
Board of Directors	
Last Board of Directors Review	

Developed: March 21, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Compensation of the Chief Executive Officer	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: The Chief Executive Officer (CEO) of Northern Inyo Healthcare District (NIHD) is the person responsible for the efficient operation of NIHD. Therefore, it is the desire of the NIHD Board of Directors to provide a fair compensation (salary and benefits) to the CEO.

POLICY:

1. Annually (as of hire date) the NIHD Board of Directors shall evaluate the performance and review the compensation of the Chief Executive Officer to determine if an adjustment to compensation is appropriate.

PROCEDURE:

1. The BOD President shall appoint two members of the BOD as an Ad Hoc committee to research comparability data of similar organizations and similar qualified individuals.
2. At a BOD meeting (may be during closed session), the Ad Hoc committee will make a recommendation to the full BOD for any compensation (salary and/or benefits) adjustments based on a review of the data and CEO Performance Review.
3. During the Open Session of the Meeting Agenda, the BOD President will report any action taken on the recommendation. The meeting at which the compensation adjustment is approved the minutes are to include the documentation of how the BOD reached its decisions and the effective date.

REFERENCES:

1.

CROSS REFERENCE P&P:

1.

Approval	**Date**
Board of Directors	
Last Board of Directors Review	

Developed: March 21, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Authority of the Chief Executive Officer for Contracts and Bidding	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

PURPOSE: Establish policy and procedure process for Authority for Contracts and Bidding.

POLICY:

Northern Inyo Healthcare District (NIHD) shall comply with the requirements of California Health and Safety Code Section 32132, which set forth competitive means bidding requirements. “Competitive means” includes any appropriate means specified by the Board of Directors (BOD), including, but not limited to, the preparation and circulation of a request for a proposal to an adequate number of qualified sources, as determined by the BOD in its discretion, to permit reasonable competition consistent with the nature and requirements of the proposed acquisition.

When the BOD awards a contract through competitive means, the district's requirements, as determined by the evaluation criteria specified by the board. The evaluation criteria may provide for the selection of a vendor on an objective basis other than cost alone.

PROCEDURE:

1. NIHD “shall acquire materials and supplies that cost more than twenty-five thousand dollars ($25,000) through competitive means, except when the board determines either that (1) the materials and supplies proposed for acquisition are the only materials and supplies that can meet the district's need, or (2) the materials and supplies are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety.” (Ca. H&S Code Section 32132)
2. This bidding process “Shall not apply to medical or surgical equipment or supplies, to professional services, or to electronic data processing and telecommunications goods and services. Medical or surgical equipment or supplies includes only equipment or supplies commonly, necessarily, and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in a hospital.” (Ca. H&S Code Section 32132)
3. “Bids need not be secured for change orders that do not materially change the scope of the work as set forth in a contract previously made if the contract was made after compliance with bidding requirements, and if each individual change order does not total more than 5% (five percent) of the contract.” (Ca. H&S Code Section 32132)
4. The professional services to which the bidding rules do not apply include those of persons who are highly skilled in their science or profession; persons such as Attorney At Law, architect, engineer or artist; and persons whose work requires skill and technical learning and ability of a rare kind.
5. The hospital administrator or designated staff shall mail notice of the action or decision to the affected applicant or medical staff member within the time specified in the applicable bylaw or rule.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Authority of the Chief Executive Officer for Contracts and Bidding	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

REFERENCES:

1. California Health and Safety Code Section 32132

Approval	**Date**
Board of Directors	05/16/2018
Last Board of Directors Review	05/16/2018

Developed: March 26, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Requests For Public Funds, Community Grants, Sponsorships	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

PURPOSE: Establish criteria for granting requests for Public Funds, Community Grants, and Sponsorships. A community's health needs are served not only by traditional acute care hospitals, but also by a broad array of other health-related programs and initiatives. These include local health and wellness programs, community based clinics, health provider educational programs, and other programs and organizations that promote physical health, emotional health, and behavioral health well-being.

POLICY:

As allowed by Northern Inyo Health Care District's (NIHD) financial condition and the law, the District may provide assistance to Healthcare programs, services, facilities and activities at any location within or without the NIHD for benefit of the District and the people served by the District.

PROCEDURE:

1. When considering funding a request, NIHD shall address identified community healthcare needs as envisioned by the Mission and Vision Statements and the strategic plan.
2. Within the limits of the budget and the law, sponsorship of events of qualified programs is allowed. NIHD staff will administer sponsorship requests.
3. In conjunction with setting the annual budget each year, the District shall determine whether to fund any requests for Community Grants and if so, what amount. NIHD staff shall administer the Community Grants program with the Directors making the final decision regarding grant recipients.
4. Information regarding the availability of the Community Grants and the application process shall be posted on the NIHD website and publicized appropriately so eligible programs may make timely applications.

REFERENCES:

1. California Health and Safety Code Sections 32121(j) and 32126.5.

Approval	**Date**
Board of Directors	05/16/2018
Last Board of Directors Review	05/16/2018

Developed: March 26, 2018
Reviewed:
Revised:
Supersedes:
Index Listings

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Use by NIHD Directors of District Email Accounts	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

PURPOSE: Establish policy and procedure for appropriate use of the District's official email accounts by Northern Inyo Healthcare District (NIHD) Board of Directors (BOD)

POLICY:

1. The District shall issue an official email address, using the District's domain name for all Directors.
2. The District shall provide technical support to enable Directors to access their official email accounts from mobile devices and home computers.
3. No Director shall conduct District business on any email account other than the official District email account.
4. Director's emails pertaining to District business shall not be deleted during the Director's term of office.
5. Non-District related emails may be deleted at the Directors discretion.
6. All emails related to District business are understood to be a part of the public record.

PROCEDURE:

1. Communications from District staff to Directors regarding District business shall utilize the Directors official email accounts. A Director may not request, such communications be sent to a different email account.
2. Directors are required to use their official email for District-related communications. Email communications on a Director's personal or business account that relate to District business are subject to disclosure under the Public Records Act. Directors who knowingly or inadvertently use a personal or other business account shall make their personal and/or business email account available for review by the District's legal counsel when necessary to comply with a request under the Public Records Act.
3. The Director shall not delete any District Board related emails until such time as approved copies have been saved and stored in the District IT system.
4. In order to avoid inadvertent violations of the Brown Act, Directors and staff shall exercise caution when using the "reply all" email function. Directors may not communicate with more than one other Director including via email, except for trivial or scheduling matters. It is to be understood that comments or questions in a "reply all" response may constitute a serial meeting under the Brown Act.

REFERENCES:

1. Public Records Act
2. Ralph M. Brown Act

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Use by NIHD Directors of District Email Accounts	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

Approval	**Date**
Board of Directors	05/16/2018
Last Board of Directors Review	05/16/2018

Developed: April 2, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Officers and Committees of the Board of Directors	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Describe the District officers and Board Committees and their duties.

POLICY:

1. The officers of the Northern Inyo Healthcare District (NIHD) Board of Directors (BOD shall be a President, Vice President, Secretary, Treasurer, and Member at Large.
2. The Board of Directors may sit as a Committee of the Whole or as Task Force Committees as deemed appropriate.
3. The President of the Board shall appoint such Ad Hoc committees as may be deemed necessary or advisable by the President or by the BOD. The duties of an Ad Hoc committee shall be outlined at the time of appointment, and the committee shall be deemed dissolved when its final report has been made.
4. As provided in the BOD By-Laws, no committee so appointed shall have any power or authority to commit the BOD or the District in any manner unless the BOD directs the committee to act for and on its behalf by special vote.

PROCEDURE:

1. The Board of Directors at the December meeting of every calendar year shall choose the officers of the Board every year. Each officer shall hold office for one year or until a successor shall be elected and qualified or until the officer is otherwise disqualified to serve.
2. Any officer of the BOD may resign or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the BOD. In the event of resignation or removal of an officer the BOD shall elect a successor to serve for the balance of that officer's unexpired term.
3. The **President** shall conduct the meetings of the BOD and shall act as the lead liaison between the BOD and District Management for communications and oversight in fulfilling the District's Mission, Vision and Values. The President shall have, subject to the advice and control of the BOD, general responsibility of the affairs of the District and shall discharge all other duties that shall be required of the President by the By-Laws of the BOD.
4. The **Vice President** shall in the event of absence or inability of the President, exercise all the powers and perform all the duties given to the President by the By-Laws of the District.
5. The **Secretary** shall act in this capacity for both the District and the BOD. In the absence or inability of the President and Vice President shall exercise all powers and perform all duties given to the President. Shall be responsible for seeing that all actions, proceedings and minutes of the meetings of the BOD are properly kept and are maintained at District Administrative offices. Shall perform such other duties as pertains to the office and as prescribed by the BOD and By-Laws of the BOD. The Secretary may delegate his/her duties to appropriate management personnel.
6. The **Treasurer** shall be responsible for the safekeeping and disbursal of the funds of the District in accordance with the provisions of the "Local Healthcare District Law: and in accordance with resolutions, procedures and directions as the BOD may adopt. Shall perform such other duties as pertains to the office and as prescribed by the BOD and By-

Title: Officers and Committees of the Board of Directors	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

Laws of the BOD. The Treasurer may delegate his/her duties to appropriate management personnel.

7. The **Member at Large** shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the BOD and By-Laws of the BOD.
8. The duties of the **committees** shall be to develop and make policy recommendations to the BOD and to perform such other functions as shall be stated in the BOD By-Laws or in the resolution or motion creating the committee. The President with the approval of the BOD may appoint special or Ad Hoc committees as special circumstances warrant. Composition of the committee may consist of only Board members or they may include individuals not on the Board.

REFERENCES:

1. Northern Inyo Healthcare District Board of Directors By-Laws

CROSS REFERENCE P&P:

1.

Approval	**Date**
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Public Records Requests	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Establish guidelines for the Northern Inyo Healthcare District (NIHD) Board of Directors (BOD) to follow when there is a request for information under the California Public Records Act

POLICY:

1. All California Public Records Act requests made to a BOD member for NIHD related information are to be referred to the Compliance Officer.

DEFINITIONS:

California Public Records Act – The fundamental precept of the California Records Act is that governmental records shall be disclosed to the public, upon request, unless there is a specific reason not to do so.

Public Records – Any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by the entity regardless of physical form or characteristics.

PROCEDURE:

1. Requests made to a Director to inspect and copy public records shall be referred directly to the Compliance Office.
2. As NIHD is required to "assist the member of the public in making a focused and effective request that reasonably describes an identifiable record" or "on the facts of the particular case the public interest served by not making the record public clearly outweighs the public interest served by disclosure of the record", no opinion of what may or may not be exempt from disclosure is to be inferred by a Director.

REFERENCES:

1. California Government Code (6250), 6252(e), 6253.1(a), 6255(a)

CROSS REFERENCE P&P:

1. NIHD California Public Records Act – Information Requests Policy

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Public Records Requests	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

Approval	**Date**
Board of Directors	
Last Board of Directors Review	

Developed: April 18, 2018
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Northern Inyo Healthcare District Board of Directors Conflicts of Interest	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

PURPOSE: Establish ethical standards for governing conflicts of interest for Northern Inyo Healthcare District (NIHD) Board of Directors (BOD). This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to this organization.

POLICY:

1. All Directors shall be held to the highest ethical standard and shall not have conflicts of interest when making decisions, except when permitted by law.
2. Sources of rule that address financial conflicts of interest are The Political Reform Act (CA Government Code Section 87110 et seq.), CA Government Code Section 1090 and the common law prohibition against conflicts of interest.
3. A Director is bound to exercise the powers conferred on them with disinterest and diligence and primarily for the benefit of the public.

PROCEDURE:

1. The Political Reform Act requires each Director to file a Form 700 Statement of Economic Interests upon assuming office, annually while in office, and upon leaving office.
2. The Form 700 shall be completed and filed in compliance with the District Board's Conflict of Interest Policy and applicable state law.
3. In signing the Form 700 a Director is certifying under penalty of perjury the information is true and correct.
4. It is the responsibility of each Director to review each schedule and its instructions carefully and to complete the form accurately and comprehensively.
5. During a meeting, a Director with a conflict (or who think he/she may have a conflict) with a proposed matter on the agenda is required to disclose the conflict or potential conflict.
6. After disclosure of the financial interest and all material facts, and after any discussion with the Director, the Director will leave the meeting while the determination of a conflict of interest is discussed and voted on by the remaining BOD members.
7. If necessary, the President shall appoint a disinterested person or committee to investigate alternatives to the proposed matter.
8. A Director with a conflict is prohibited from making or in any way attempting to use his/her official position to influence a decision in which they know or would have reason to know he/she may have a financial interest.
9. A Director is prohibited from voting on any matter in which there is a conflict of interest.
10. Minutes of board meetings shall reflect when a Director discloses he/she has a conflict of interest and how the conflict was managed. Such as there was a discussion on the matter without the Director present in the room, and a vote was taken and the Director abstained.
11. Each Director is required to annually complete the District's Conflict of Interest Statement as well.
12. Decisions of the BOD shall be consistent with the Mission and Vision Statements and the Strategic Plan adopted by the NIHD BOD.

Title: Northern Inyo Healthcare District Board of Directors Conflicts of Interest	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

REFERENCES:
1. CA Government Code Section 87110 et seq
2. CA Government Code Section 1090

CROSS REFERENCE P&P:
1. Northern Inyo Healthcare District's Conflict of Interest Policy

Approval	**Date**
Board of Directors	05/16/2018
Last Board of Directors Review	05/16/2018

Developed: March 31, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Northern Inyo Healthcare District Board of Directors Conflicts of Interest	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

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2. The Form 700 shall be completed and filed in compliance with the District Board's Conflict of Interest Policy and applicable state law.
3. In signing the Form 700 a Director is certifying under penalty of perjury the information is true and correct.
4. It is the responsibility of each Director to review each schedule and its instructions carefully and to complete the form accurately and comprehensively.
5. During a meeting, a Director with a conflict (or who think he/she may have a conflict) with a proposed matter on the agenda is required to disclose the conflict or potential conflict.
6. After disclosure of the financial interest and all material facts, and after any discussion with the Director, the Director will leave the meeting while the determination of a conflict of interest is discussed and voted on by the remaining BOD members.
7. If necessary, the President shall appoint a disinterested person or committee to investigate alternatives to the proposed matter.
8. A Director with a conflict is prohibited from making or in any way attempting to use his/her official position to influence a decision in which they know or would have reason to know he/she may have a financial interest.
9. A Director is prohibited from voting on any matter in which there is a conflict of interest.
10. Minutes of board meetings shall reflect when a Director discloses he/she has a conflict of interest and how the conflict was managed. Such as there was a discussion on the matter without the Director present in the room, and a vote was taken and the Director abstained.
11. Each Director is required to annually complete the District's Conflict of Interest Statement as well.
12. Decisions of the BOD shall be consistent with the Mission and Vision Statements and the Strategic Plan adopted by the NIHD BOD.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Northern Inyo Healthcare District Board of Directors Conflicts of Interest	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 05/16/2018

REFERENCES:
1. CA Government Code Section 87110 et seq
2. CA Government Code Section 1090

CROSS REFERENCE P&P:
1. Northern Inyo Healthcare District's Conflict of Interest Policy

Approval	**Date**
Board of Directors	05/16/2018
Last Board of Directors Review	05/16/2018

Developed: March 31, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

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

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	1,222,509	804,423	418,086	8,821,297	7,110,053	1,711,244
Ancillary	3,181,792	2,790,390	391,402	25,185,966	24,663,464	522,502
Total Inpatient Service Revenue	4,404,301	3,594,813	809,488	34,007,263	31,773,517	2,233,746
Outpatient Service	9,236,657	8,119,362	1,117,295	77,460,188	71,764,656	5,695,532
Gross Patient Service Revenue	**13,640,958**	**11,714,175**	**1,926,783**	**111,467,451**	**103,538,173**	**7,929,278**
Less Deductions from Revenue						
Patient Service Revenue Deductions	287,998	234,723	53,275	2,112,549	2,074,649	37,900
Contractual Adjustments	5,521,656	4,493,004	1,028,652	46,323,303	39,712,355	6,610,948
Prior Period Adjustments	(33,362)	(13,400)	(19,962)	(1,686,225)	(118,437)	(1,567,788)
Total Deductions from Patient Service Revenue	**5,776,291**	**4,714,327**	**1,061,964**	**46,749,627**	**41,668,567**	**5,081,060**
Net Patient Service Revenue	**7,864,667**	**6,999,848**	**864,819**	**64,717,825**	**61,869,606**	**2,848,219**
Other revenue	74,620	76,819	(2,199)	444,867	678,983	(234,116)
Total Other Revenue	**74,620**	**76,819**	**(2,199)**	**444,867**	**678,983**	**(234,116)**
Expenses:						
Salaries and Wages	2,255,505	2,328,739	(73,234)	19,174,082	20,583,047	(1,408,965)
Employee Benefits	1,918,680	1,589,908	328,772	14,479,509	14,052,742	426,767
Professional Fees	1,172,124	724,509	447,615	9,354,888	6,403,734	2,951,154
Supplies	892,831	648,488	244,343	6,623,554	5,731,788	891,766
Purchased Services	354,238	360,086	(5,848)	2,790,421	3,182,698	(392,277)
Depreciation	169,067	443,023	(273,956)	3,439,551	3,915,749	(476,198)
Bad Debts	311,222	242,784	68,438	2,235,153	2,145,897	89,256
Other Expense	399,818	352,700	47,118	3,671,863	3,117,422	554,441
Total Expenses	**7,473,486**	**6,690,237**	**783,249**	**61,769,021**	**59,133,077**	**2,635,944**
Operating Income (Loss)	**465,801**	**386,430**	**79,371**	**3,393,671**	**3,415,512**	**(21,841)**
Other Income:						
District Tax Receipts	43,955	49,096	(5,141)	395,595	433,947	(38,352)
Tax Revenue for Debt	128,647	165,487	(36,840)	1,157,821	1,462,690	(304,869)
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	-	42,466	(42,466)	1,529,932	375,344	1,154,588
Interest Income	26,832	16,845	9,987	265,204	148,889	116,315
Interest Expense	(238,173)	(260,547)	22,374	(2,229,065)	(2,302,899)	73,834
Other Non-Operating Income	2,812	2,422	390	39,773	21,408	18,365
Net Medical Office	(464,909)	(396,696)	(68,213)	(3,343,330)	(3,506,288)	162,958
340B Net Activity	-	16,987	(16,987)	(3,251)	150,143	(153,394)
Non-Operating Income/Loss	**(500,837)**	**(363,940)**	**(136,897)**	**(2,187,322)**	**(3,216,766)**	**1,029,444**
Net Income/Loss	**(35,036)**	**22,490**	**(57,526)**	**1,206,349**	**198,746**	**1,007,603**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

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

Year to date for the month ending March 31, 2018

	249	or	9.4%	more IP days than in the prior fiscal year
$	2,233,746	or	7.0%	over budget in Total IP Revenue and
$	5,695,532	or	7.9%	over budget in OP Revenue resulting in
$	7,929,278	or	7.7%	over budget in gross patient revenue &
$	2,848,219	or	4.6%	over budget in net patient revenue

Year-to-date Net Revenue was			$	64,717,825
Total Operating Expenses were:			$	61,769,021
			for the fiscal Year To Date	
$ 2,635,944	or	4.5%	over budget. Salaries and Wages were	
$ (1,408,965)	or	-6.8%	under budget and Employee Benefits	
$ 426,767	or	3.0%	over budget	
		76%	Employee Benefits as Percentage of Wages	

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

$	2,951,154	or	46.1%	Professional Fees are over budget due to contract labor budgeted as employees
$	554,441	or	17.8%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending

Other Information:

$ 3,393,671				Operating Income, less
$ (2,187,322)				loss in non-operating activities resulted in a Net
$ 1,206,349	or	$	1,007,603	over budget.
			41.94%	Actual Contractual Percentages for Year versus
			40.24%	Budgeted Contractual Percentages including

$ 1,686,225 in prior year cost report favorable settlement activity for Medicare & Medi-Cal

Non-Operating activities included:

$ (3,343,330)	loss	$	162,958	favorable to budget in Medical Office Activities
$ 1,529,932		$	1,154,588	favorable to budget in Grants and Other Contributions

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

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	2,724,222	9,665,123	(6,940,901)
Short-Term Investments	8,859,199	8,990,039	(130,840)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	63,863,634	63,663,215	200,418
Less: Allowances	(47,177,291)	(47,471,997)	294,706
Other Receivables	6,999,482	1,375,941	5,623,541
Inventories	5,066,928	4,012,133	1,054,795
Prepaid Expenses	1,653,202	1,694,749	(41,547)
Total Current Assets	**43,083,405**	**43,023,233**	**60,172**
Internally Designated for Capital Acquisitions	1,125,397	1,125,364	33
Special Purpose Assets	964,558	1,269,481	(304,923)
Limited Use Asset; Defined Contribution Pension	1,281,570	1,150,730	130,840
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	11,572	10,445	1,128
Revenue Bonds Held by a Trustee	2,688,177	2,527,091	161,087
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,436,659**	**19,448,495**	**(11,836)**
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated Depreciation	77,685,621	77,328,068	357,553
Unamortized Bond Costs	-	-	-
Total Assets	**141,955,685**	**141,549,796**	**405,889**

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

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,110,089	2,115,347	(5,258)
Accounts Payable	3,487,524	2,355,196	1,132,327
Accrued Salaries, Wages & Benefits	5,856,011	5,493,319	362,693
Accrued Interest and Sales Tax	249,550	442,930	(193,380)
Deferred Income	494,710	1,394,916	(900,206)
Due to 3rd Party Payors	1,020,165	1,099,914	(79,749)
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	4,518,388	4,517,261	1,128
Total Current Liabilities	**17,736,437**	**17,418,882**	**317,555**
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	556,234	563,480	(7,247)
Accreted Interest	11,862,033	11,751,484	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**84,745,746**	**84,642,444**	**103,302**
Net Assets			
Unrestricted Net Assets less Income	38,508,945	38,218,990	289,955
Temporarily Restricted	964,558	1,269,481	(304,923)
Net Income (Income Clearing)	(1,206,592)	(1,241,628)	35,036
Total Net Assets	**39,473,503**	**39,488,471**	**(14,968)**
Total Liabilities and Net Assets	**141,955,685**	**141,549,796**	**405,889**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending March 31, 2018

	Month to Date	FYE 2018 Year-to-Date	FYE 2017 Year-to-Date	Variance from PY	Variance %
Licensed Beds	25	25	25		
Total Patient Days with NB	408	2,906	2,657	249	9%
Total Patient Days without NB	377	2,652	2,393	259	11%
Swing Bed Days	91	371	322	49	15%
Discharges without NB	98	824	805	19	2%
Swing Discharges	12	51	50	1	2%
Days in Month	31	31	31		
Occupancy without NB	12.16	85.55	77.19	8.4	11%
Average Stay (days) without NB	3.85	3.22	2.97	0.2	8%
Average LOS without NB/Swing	3.33	2.95	2.74	0.2	8%
Hours of Observation	912	8,025	6,950	1,075	15%
Observation Adj Days	38	334	290	45	15%
ER Visits All Visits	806	7,210	7,457	(247)	-3%
RHC Visits	2,225	22,902	20,472	2,430	12%
Outpatient Visits	4,016	35,244	33,034	2,210	7%
IP Surgeries	26	187	208	(21)	-10%
OP Surgery	101	962	901	61	7%
Worked FTE's	354.40	343.34	329.47	14	4%
Paid FTE's	385.94	388.36	369.43	19	5%
Hours Worked to Hours Paid%	91.8%	88.4%	89.2%	-0.8%	-1%
Payor %					
Medicare		43%	41%	2%	
Medi-Cal		20%	23%	-3%	
Insurance, HMO & PPO		34%	33%	1%	
Indigent (Charity Care)		0.9%	1.2%	-0.2%	
All Other		2%	2%	0%	
Total		100%	100%		

Northern Inyo Healthcare District

Preliminary Financial Indicators as of March 31, 2018

	Target	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17
Current Ratio	>1.5-2.0	2.43	2.47	2.50	2.41	2.18	2.26	2.45	2.42	2.49	3.39	3.83	3.51	3.41
Quick Ratio	>1.33-1.5	1.66	2.06	2.09	1.99	1.83	1.84	1.82	1.81	2.05	2.84	3.23	2.96	2.88
Days Cash on Hand prior method	>75	137.59	168.44	166.36	165.72	169.35	165.31	140.47	142.06	160.31	154.70	160.60	159.55	160.80
Days Cash on Hand Short Term	>75	51.38	83.49	81.30	83.05	87.18	81.28	53.95	59.26	79.93	79.37	75.71	76.12	77.66
Debt Service Coverage	>1.5-2.0	2.52	2.68	2.73	2.67	2.74	2.78	2.79	2.87	2.34	1.81	1.96	1.91	2.07
Operating Margin		5.18	5.09	4.87	5.79	5.87	7.64	7.49	8.45	6.67	4.71	6.18	6.06	6.01
Outpatient Revenue % of Total		69.49	69.74	69.53	69.25	69.52	69.46	69.13	69.83	66.58	69.86	69.96	69.76	69.43
Cash flow (CF) margin (EBIDA to revenue)		3.53	4.17	4.31	4.05	4.30	4.69	4.82	5.62	3.68	2.48	2.84	2.59	3.41
Days in Patient Accounts Receivable	<60 Days	81.50	85.60	85.90	82.80	81.80	81.40	82.10	81.40	74.10	78.90	89.00	86.00	85.10

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

Restricted and Specific Purpose Fund Balances

for period ending March 31, 2018

	Current Month	Prior Month	Change
Board Designated Funds:	March		
Tobacco Fund Savings Account	$ 1,098,670	$ 1,098,638	32
Equipment Fund Savings Account	$ 26,727	$ 26,726	1
Total Board Designated Funds:	**$ 1,125,397**	**$ 1,125,364**	**$ 33**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 834,044	$ 1,158,904	$ (324,860)
Nursing Scholarship Savings Account	$ 30,448	$ 10,448	$ 20,000
Medical Education Savings Account	$ -	$ 75	$ (75)
Joint NIHD/Physician Group Savings Account	$ 100,066	$ 100,053	$ 12
Total Specific Purpose Funds:	**$ 964,558**	**$ 1,269,481**	**$ (304,923)**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,089,954**	**$ 2,394,845**	**$ (304,890)**

NORTHERN INYO HEALTHCARE DISTRICT

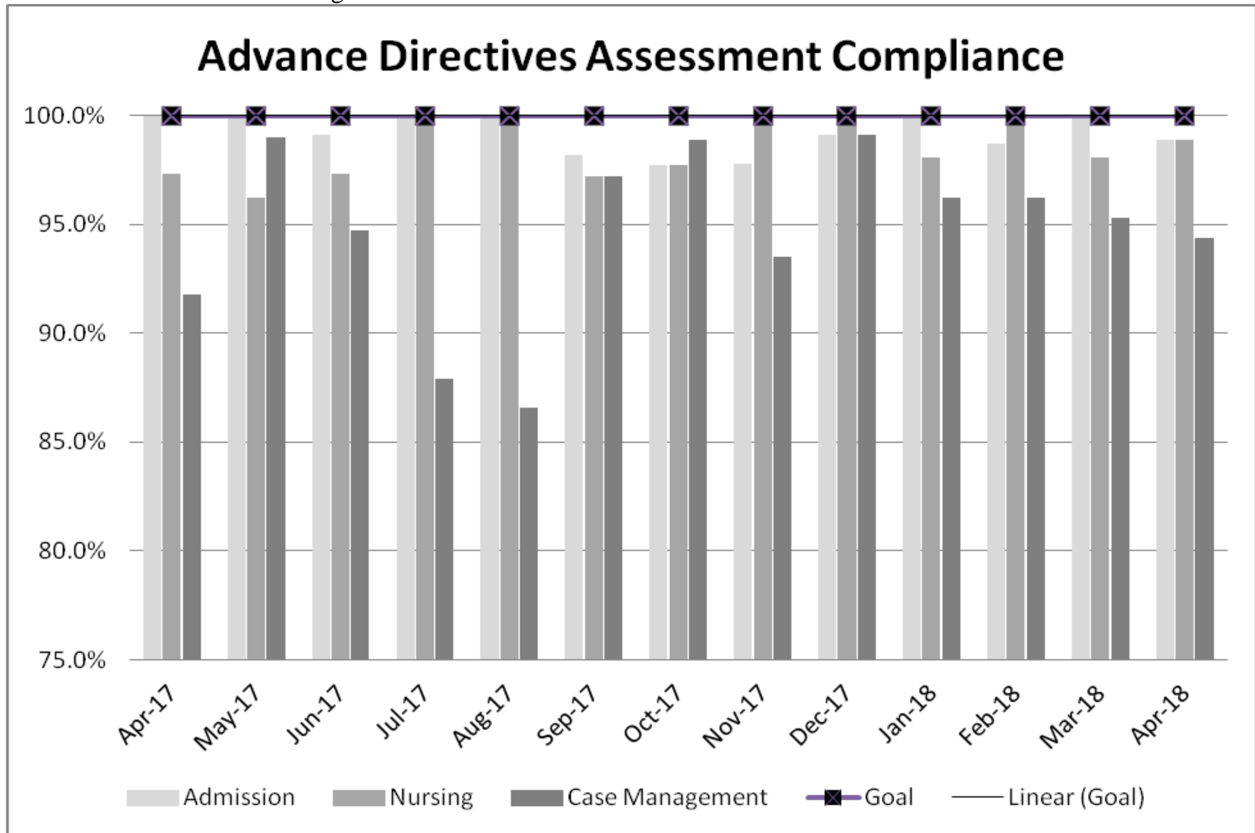
Investments as of March 31, 2018

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	31-Mar-18	01-Apr-18	Local Agency Investment Fund	Northern Inyo Hospital	1.52%		8,609,198.53
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				Short Term Investments			8,859,198.53
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				Long Term Investments		$	1,750,000.00
				Total Investments		$	10,609,198.53
1	31-Mar-18	01-Apr-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.52%	$	1,281,569.80
				LAIF PENSION INVESTMENTS		$	1,281,569.80

2013 CMS Validation Survey Monitoring-May 2018

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

    a. Advance Directives Monitoring.

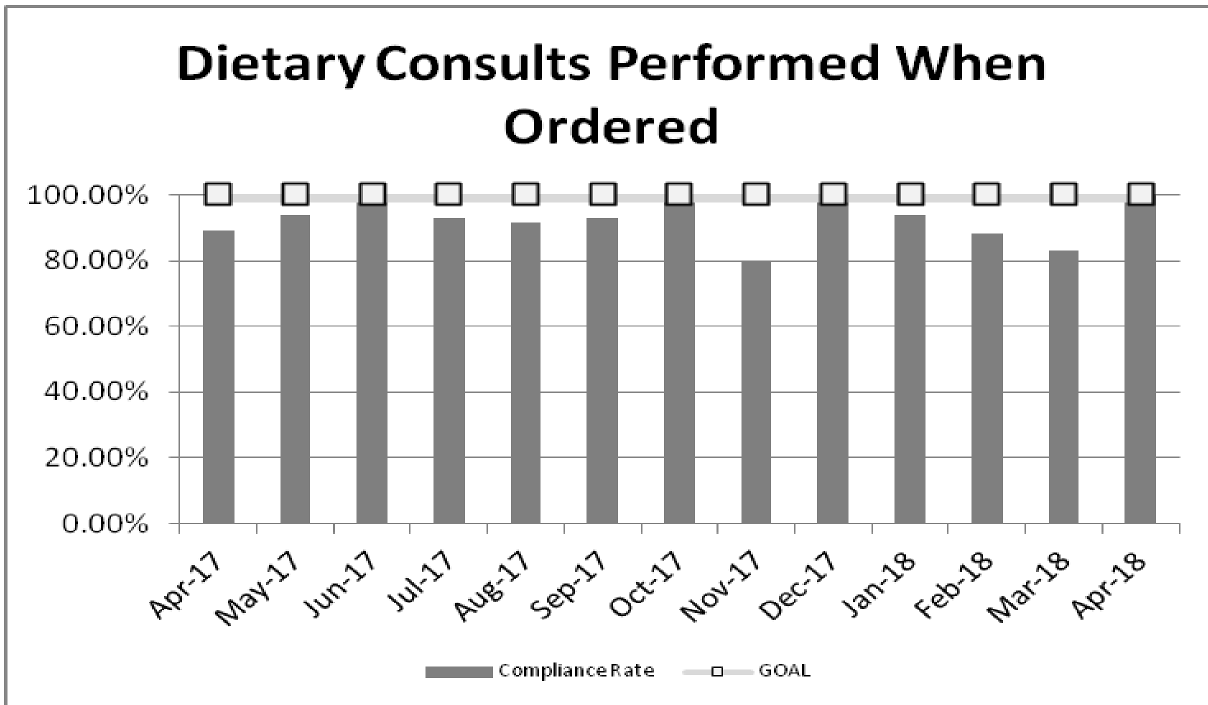


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

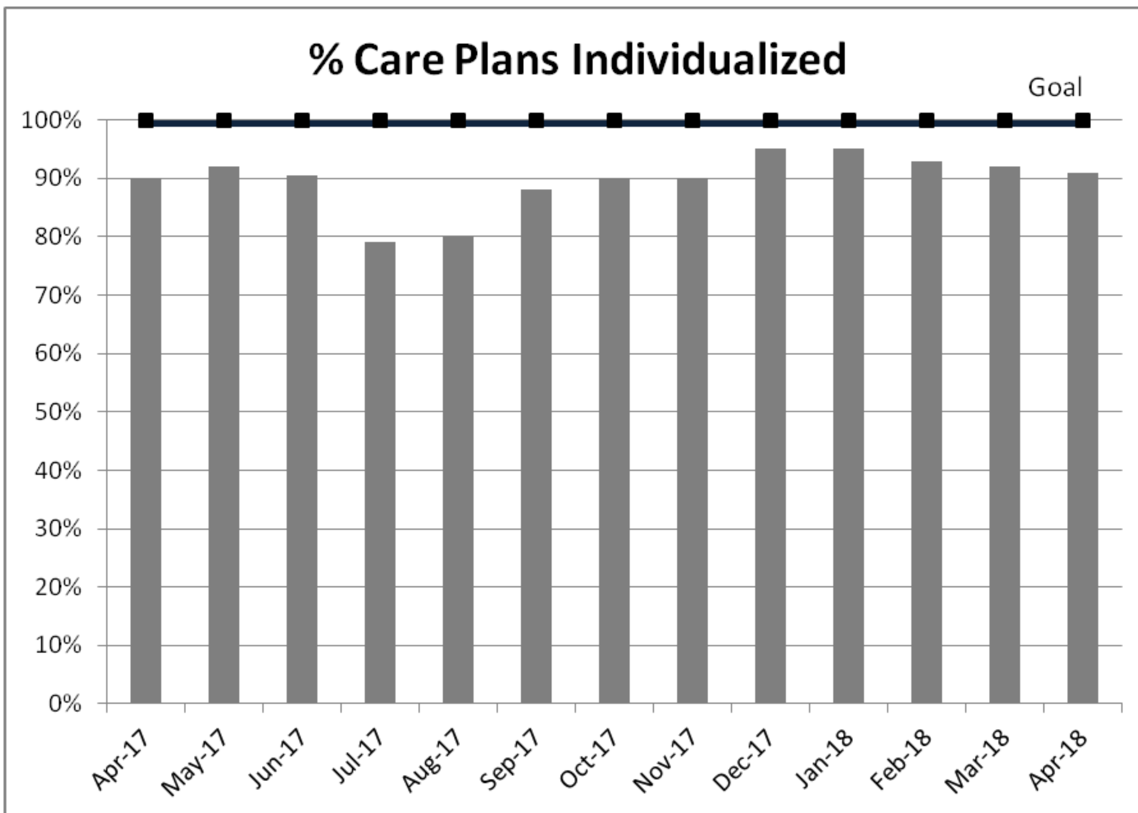
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

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

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

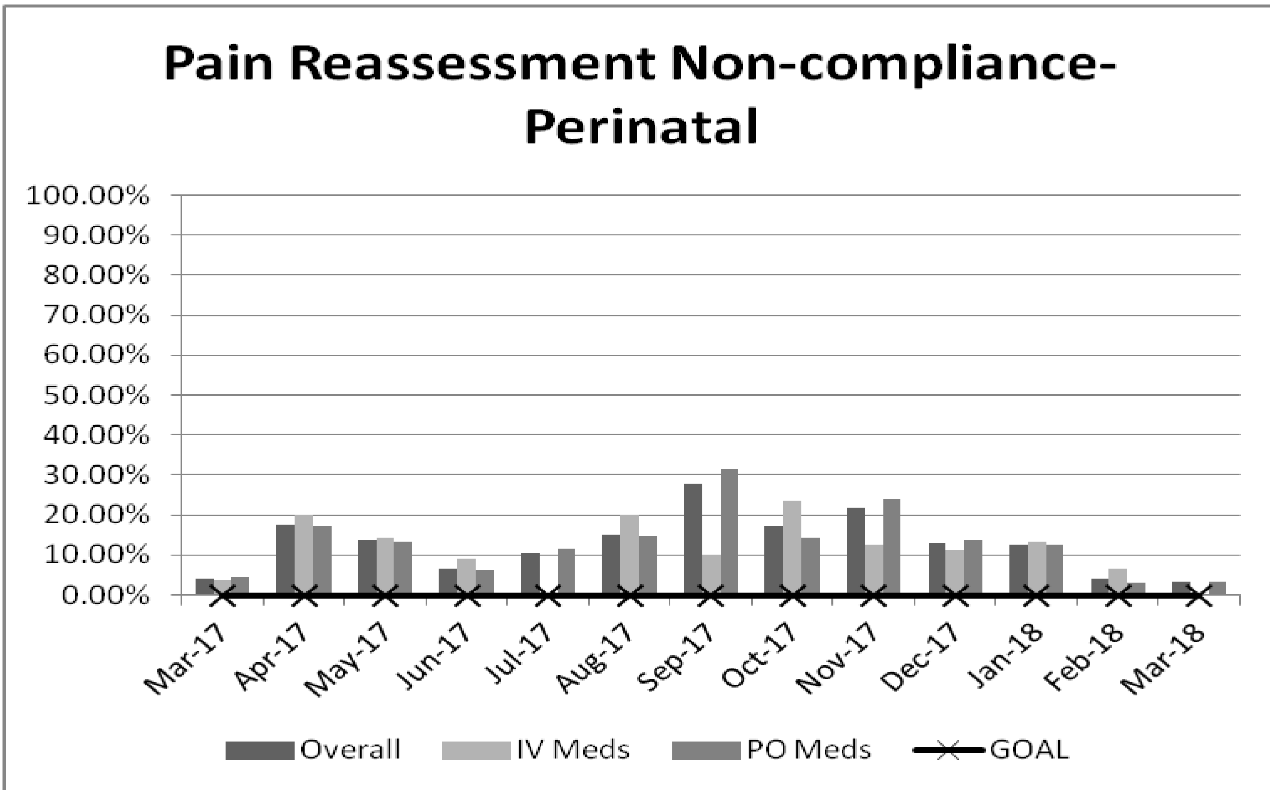


f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.



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

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



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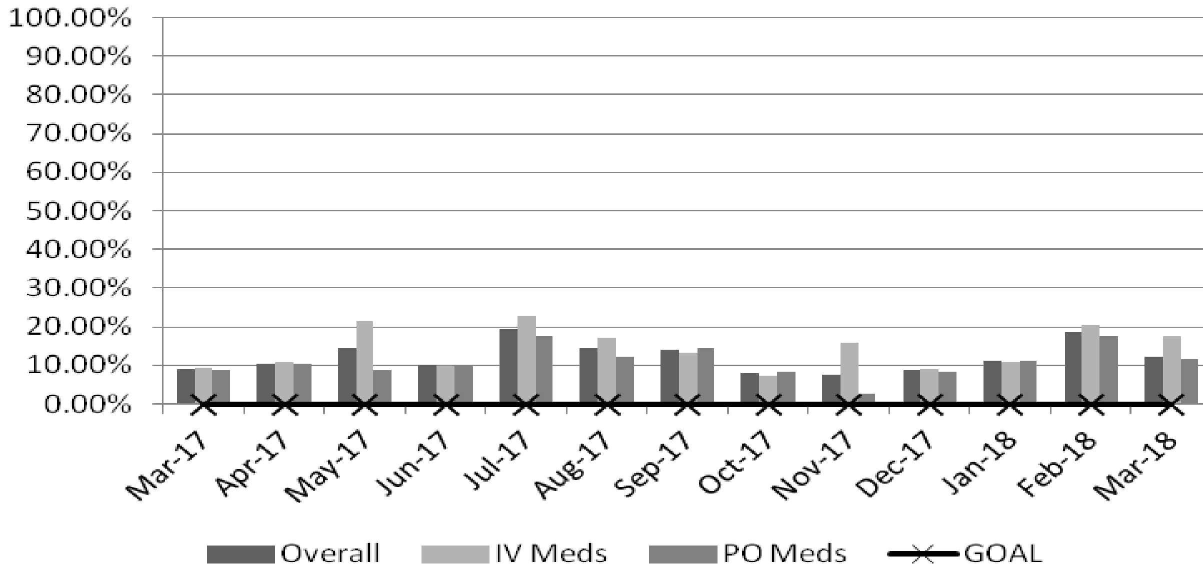

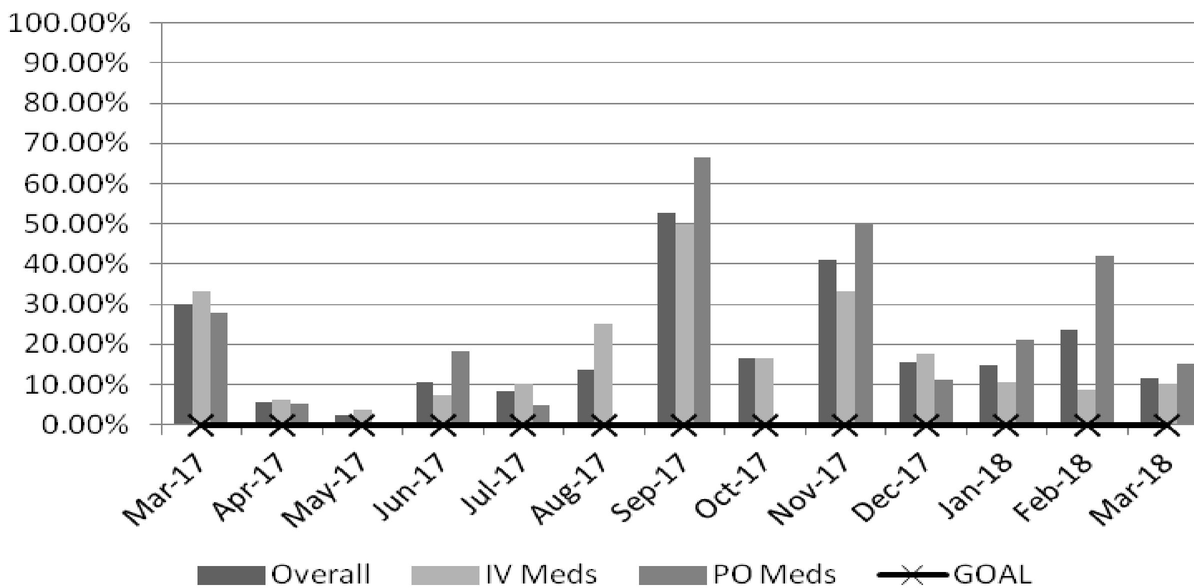

Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.

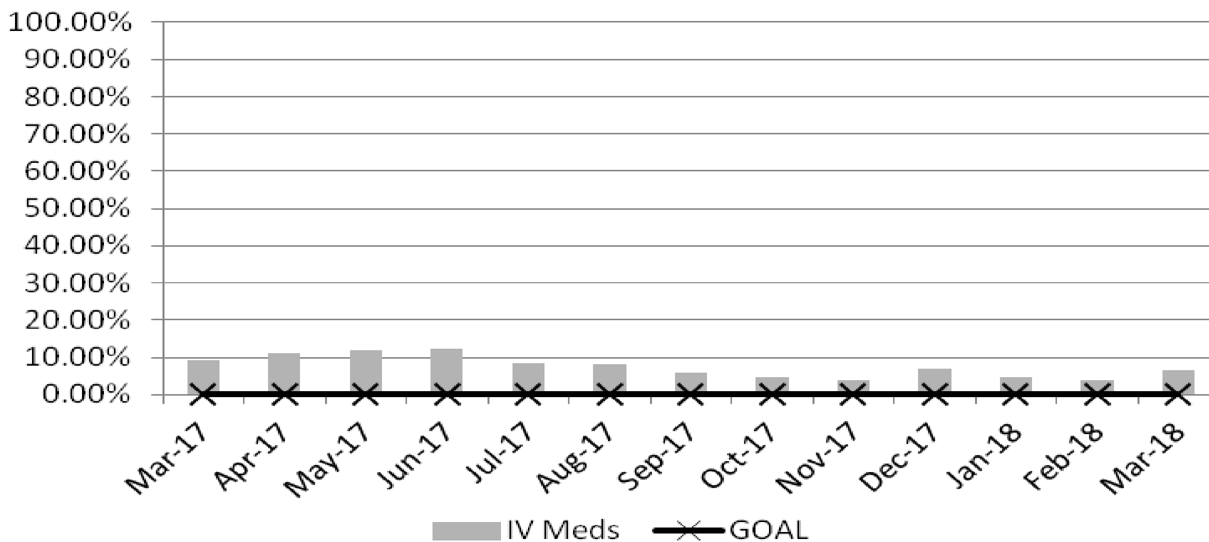

Table 6. Restraint chart monitoring for legal orders.

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

CALL TO ORDER	The meeting was called to order at 5:30 pm by John Ungersma MD, President.
PRESENT	John Ungersma MD, President M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Sandy Blumberg, Executive Assistant
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma stated at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. Barbara Meinke spoke in praise of Thomas McNamara MD, stating his value to this community and requesting that the Board reach out to him and ask that he consider continuing to practice in this area.
NEW BUSINESS	
RECOMMENDED CAPITAL BUDGET FOR 2018/2019 FISCAL YEAR	Chief Financial Officer John Tremble presented capital budget requests for the 2018/2019 fiscal year, stating they were determined following careful review and consideration by Northern Inyo Healthcare District (NIHD) leadership and the NIHD Medical Executive Committee. Proposed capital expenditures for the upcoming year total $3,150,000 and are based on a careful assessment of the District's priority needs and Office of Statewide Healthcare Planning and Development (OSHPD) requirements. Mr. Tremble noted the capital budget being presented should allow the District to have 90 days cash on hand at fiscal year end, and that it is possible a mid-year addition to the capital budget may be submitted assuming the successful completion of the District's Athena Health Information System implementation. It was moved by Mary Mae Kilpatrick, seconded by M.C. Hubbard, and unanimously passed to approve the fiscal year 2018/2019 capital expenditure requests as presented. It was also noted that the operating budget for the upcoming fiscal year will be presented for approval at the May regular meeting.
FINANCIAL AND STATISTICAL REPORTS AS OF FEBRUARY 2018	Mr. Tremble reviewed the Financial and Statistical Reports as of February 28 2018 and provided an overview of District volume, revenue, and expenditures, which resulted in a net income of $47,506. Mr. Tremble noted year-to-date net income as of February 2018 totals $1,065,130, and that District assets continue to grow. It was moved by Jean Turner, seconded by Ms. Hubbard, and unanimously passed to approve the

Financial and Statistical Reports as of February 28 2018 as presented.

CHART CHECK GUIDELINES POLICY AND PROCEDURE	Chief Nursing Officer Tracy Aspel, RN called attention to a proposed Policy and Procedure titled *Chart Check Guidelines*. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the proposed *Chart Check Guidelines* Policy and Procedure as presented.
REVISED COMPLIANCE AND PRIVACY POLICIES AND PROCEDURES	Compliance Officer Patty Dickson called attention to a revised Policy and Procedure titled *Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information*. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the revised *Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information* Policy and Procedure as presented. Ms. Dickson also called attention to a revised Policy and Procedure titled *Auditing of Workforce Access to Confidential Information*. It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve the revised Policy and Procedure titled *Auditing of Workforce Access to Confidential Information* Policy as presented.
WORKFORCE EXPERIENCE COMMITTEE REPORT	Chief Human Resources Officer Evelyn Campos Diaz provided a Workforce Experience Committee report which included updates on the following: - Rollout of the District's Employee Satisfaction Survey results - Workforce trainings currently underway - Workforce development opportunities, including introduction of quality modules - Efforts to ensure a safe and secure workplace, including Workplace Violence trainings for staff Ms. Campos Diaz also reported the Workforce Experience Committee continues to promote employee work/life balance and is looking into establishing wellness initiatives for District employees.
PATIENT EXPERIENCE COMMITTEE REPORT	Chief Executive Officer (CEO) Kevin S. Flanigan, MD, MBA reported the Patient Experience Committee has accomplished much of the work specified in the District's Strategic Plan, and as a result of an organizational restructure of the Executive Team meetings, new patient experience benchmarks and measurable goals are being established to further enhance the patient experience.
MEDICAL STAFF SERVICES PILLARS OF EXCELLENCE REPORT	Doctor Flanigan also reviewed the quarterly Medical Staff Services Pillars of Excellence report, which shows a marked increase in the volume of work produced by that department with no notable decrease in the quality of work completed. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the Medical Staff Services Pillars of Excellence Report as presented.

BOARD OF DIRECTORS POLICY AND PROCEDURE APPROVALS

Doctor Flanigan additionally called attention to the following (proposed) Board of Directors Policies and Procedures:

- *Attendance At Meetings*
- *Northern Inyo Healthcare District Board of Directors Meetings*
- *Basis of Authority: Role of Directors*
- *Reimbursement of Expenses*
- *Election Procedures and Related Conduct*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve all five Board of Directors Policies and Procedures as presented, with housekeeping corrections being made as suggested by Director Kilpatrick.

AD HOC COMMITTEE FOR ZONE 3 BOARD VACANCY

Doctor Flanigan called attention to the need to establish an Ad Hoc Committee for the purpose of reviewing candidates and making a recommendation to fill the Board vacancy for District Zone 3. It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve Directors Turner and Hubbard to serve on an Ad Hoc Committee to address filling the District Zone 3 Board vacancy.

CONSENT AGENDA

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

- Approval of minutes of the March 21 2018 regular meeting
- 2013 CMS Survey Validation Monitoring
- Policy and Procedure annual approvals

It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve all 3 Consent Agenda items as presented.

CHIEF OF STAFF REPORT

POLICIES, PROCEDURES, PROTOCOLS, AND 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:

1. *Bite Guidelines, Animals*
2. *DI - Timely Performance Standards*
3. *Discharge Instructions Emergency Department*
4. *Pediatric Order Verification Overnight*
5. *Radiology Critical Indicators for Chart Review Policy*
6. *Safely Surrendered Baby Policy and Procedure*
7. *Scope of Service for the Emergency Department*
8. *Standards of Care for the Emergency Department*

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve all 8 Policies, Procedures, Protocols, and Order Sets as presented.

EMERGENCY ROOM SERVICE CRITICAL INDICATORS ANNUAL REVIEW

Doctor Meredick also reported the Medical Executive Committee recommends approval of the *Emergency Room Service Critical Indicators* annual review. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the *Emergency Room Service Critical*

Indicators annual review as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVELEGES

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

1. Gabriel Overholtzer, DDS (*dentistry*) – Provisional Active Staff (limited license practitioner)
2. Kinsey R. Pillsbury, MD (*radiology*) – Consulting Staff

It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve both Medical Staff Appointments and Privileges as requested.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to comment on any items of interest. Directors Turner and Ungersma reported on the Association of California Healthcare Districts (ACHD) annual Legislative Day, which was attended by three members of the District Board and the CEO. While in Sacramento for the ACHD event, NIHD representatives met with Senator Tom Berryhill and Assemblyman Devon Mathis. Director Kilpatrick also invited those present to attend the Friendship Center's upcoming Open House, and Director Turner thanked Doctor Meredick for his Healthy Lifestyles presentation for members of this community. Doctor Ungersma reminded those present about the NIHD Telehealth Open House to be held on April 24.

ADJOURNMENT TO CLOSED SESSION

At 6:34 pm Doctor Ungersma reported the meeting would adjourn to Closed Session to allow the Board of Directors to:

A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*).
B. Discuss a personnel matter (*pursuant to Government Code Section 54957.6*).
C. Discuss labor negotiations, Agency Designated Representative Kevin Dale; Employee Organization AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 7:40 pm the meeting returned to open session. Doctor Ungersma reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 7:41 pm.

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John Ungersma MD, President

Attest: ______________________________

M.C. Hubbard, Secretary

BOARD MEETING ATTENDANCE, 2018 CALENDAR YEAR

	J.UNGERSMA, MD *President*	M.C. HUBBARD *Vice President*	MARY MAE KILPATRICK *Secretary*	JEAN TURNER *Treasurer*	PETER WATERCOTT *Member at Large*
January 17, 2018 Reg.	√	√	√	√	√
January 25, 2018 Sp.	√	√	√	√	√
February 21, 2018 Reg.	√	√	√	√	√
March 21, 2018 Sp.	√	√	√	√	√ *(Resignation Submited)*
April 12, 2018 Sp.	√	√	√	√	–
April 18, 2018 Reg.	√	√	√	√	–
April 20, 2018 Sp.					
May 16, 2018 Reg.					
June 20, 2018 Reg.					
July 18, 2018 Reg.					
August 15, 2018 Reg.					
September 19, 2018 Reg.					
October 17, 2018 Reg.					
November 21, 2018 Reg.					
December 19, 2018 Reg.					

CALL TO ORDER	The meeting was called to order at 3:00 pm by John Ungersma MD, President.
PRESENT	John Ungersma MD, President M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Member At Large
ALSO PRESENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer (via telephone) Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Relations Officer Kevin Dale, Labor Counsel Sandy Blumberg, Executive Assistant
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.
CHIEF HUMAN RESOURCES OFFICER REPORT	Chief Human Resources Officer Evelyn Campos Diaz reported the District is preparing to enter into Labor Negotiations with American Federation of State, County, and Municipal Employees (AFSCME) Council 57.
ADJOURNMENT TO CLOSED SESSION	At 3:06 pm Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to conference with Labor Negotiators, Agency Designated Representative Kevin Dale, Employee Organization AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 4:12 pm the meeting returned to open session. Doctor Ungersma reported the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 4:13 pm.

____
John Ungersma MD, President

Attest: _______________________________________
Mary Mae Kilpatrick, Secretary

CALL TO ORDER	The meeting was called to order at 8:00 am by John Ungersma, President.
PRESENT	John Ungersma MD, President M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Richard Meredick MD, Chief of Staff David Sandberg, Facilitator Sandy Blumberg, Executive Assistant
ABSENT	John Tremble, Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma stated at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of 3 minutes each. No comments were heard.
PHARMACY CONSTRUCTION APPROVAL	Chief Executive Officer Kevin S. Flanigan MD, MBA requested Board approval to proceed with Phase 1 of the Northern Inyo Healthcare District (NIHD) Pharmacy rebuild project, as discussed at previous meetings. It was moved by M.C. Hubbard, seconded by Jean Turner, and unanimously passed to approve moving forward to begin Phase 1 of the NIHD Pharmacy rebuild project as requested.
DISCUSSION OF NIHD MISSION, VISION, AND VALUES	An open forum moderated by David Sandberg with Focus and Execute was held for the purpose of developing a District Values Statement to support NIHD's Mission and Vision Statements. The District Board, Chief Officers, members of the Medical Staff, and a former Board member collaborated to establish the following draft NIHD Mission, Vision, and Values Statements: MISSION STATEMENT Strong stewardship. Ethical Oversight. Eternal local access. VISION STATEMENT To be an energized, high performing advocate for the communities we serve, our patients and our staff. The Board governs with an eye on the future of health care and its effects on the District and patient care. The Board is committed to continuous evaluation, dedication to our mission, and improvements as a Board.

VALUES
The members of Northern Inyo Healthcare District Board of Directors are guided by these values in fulfilling our mission and achieving our vision:

- INTEGRITY – We believe in maintaining the highest standards of behavior encompassing honesty, ethics, loyalty, and doing the right thing for the right reason.
- INNOVATIVE VISION – We strive to be capable of extraordinary creativity and are willing to explore new approaches to improving quality of life for all persons.
- STEWARDSHIP – We are dedicated to be responsible stewards of our team, assets and financial resources, and to community service.
- TEAMWORK – We have an abiding respect for others, and a sustaining commitment to work together.

The draft Mission, Vision, and Values Statement will be rolled out to District leadership, staff, and physicians, then will be presented for Board approval at a future meeting.

ADJOURNMENT

The meeting was adjourned at 11:59 am.

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John Ungersma MD, President

Attest: ____
Mary Mae Kilpatrick, Secretary

COMPLIANCE DEPARTMENT

POLICY AND PROCEDURE ANNUAL APPROVALS

1. California Public Records Act – Information Requests

POLICY AND PROCEDURE ANNUAL APPROVALS
ENVIRONMENT OF CARE – SAFETY AND SECURITY

Title	Status	Document Owner
Access to Security Sensitive Areas EC.02.01.01EP8	Approved	Hooker, Scott
Action to Safety & Security Risks EC.02.01.01EP3	Approved	Hooker, Scott
Code Gray – Response to Combative Patient or Visitor EC.02.01.01EP9	Approved	Hooker, Scott
EOP Emergency Response Plan- Active Shooter EM.02.01.01EP2 & SS-EC.02.01.01EP9	Approved	Hooker, Scott
Evacuation	Approved	Hooker, Scott
Identification of Individuals EC.02.01.01EP7	Approved	Hooker, Scott
Lockdown	Approved	Hooker, Scott
Maintaining Grounds and Equipment	Approved	Hooker, Scott
Patients Under Legal or Correctional Restriction*	Approved	Hooker, Scott
Product Notices & Recalls EC.02.01.01EP11	Approved	Hooker, Scott
Risk Assessment for Safety and Security EC.02.01.01 EP1	Approved	Hooker, Scott

POLICY AND PROCEDURE ANNUAL APPROVALS
ENVIRONMENT OF CARE, INFORMATION COLLECTION AND MONITORING

Title	Status	Document Owner
Annual Evaluations EC.04.01.01EP15	Approved	Hooker, Scott
Environmental Tours EC.04.01.01EP12-14	Approved	Hooker, Scott
Information Collection & Monitoring EC.04.01.01EP1	Approved	Hooker, Scott
Occurrence Reporting EC.04.01.01EP3	Approved	Hooker, Scott
Reporting Fire Safety Incident EC.04.01.01EP9	Approved	Hooker, Scott
Reporting Hazardous Materials & Waste Incident EC.04.01.01EP8	Approved	Hooker, Scott
Reporting Medical Equipment Incident EC.04.01.01EP10	Approved	Hooker, Scott
Reporting Property Damage EC.04.01.01EP5	Approved	Hooker, Scott
Reporting Security Incident EC.04.01.01EP6	Approved	Hooker, Scott
Reporting Utility System Incident EC.04.01.01EP11	Approved	Hooker, Scott

POLICIES TO THE BOD
ENVIRONMENTAL

POLICY & PROCEDURES TO THE BOARD **MAY - 2018**
ENVIRONMENTAL

	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Procedures: Non-Patient Care Equipment: Mini Blinds and Vertical Blinds	05/16/2018			
2	Cleaning Procedures: Non-Patient Care Equipment: Various Non-Patient Care Items	05/16/2018			
3	Cleaning Procedures: Nursing Units: Isolation Rooms	05/16/2018			
4	Cleaning Procedures: Nursing Units: Nursing Stations	05/16/2018			
5	Cleaning Procedures: Nursing Units: Patient Care Areas	05/16/2018			
6	Cleaning Procedures: Nursing Units: Patient Restrooms	05/16/2018			
7	Cleaning Procedures: Nursing Units: Patient Room Occupied	05/16/2018			
8	Cleaning Procedures: Nursing Units: Soiled Utility Rooms	05/16/2018			
9	Cleaning Procedures: Nursing Units: Special Procedure Rooms	05/16/2018			
10	Cleaning Procedures: Nursing Units; Tub Room	05/16/2018			
11	Cleaning Procedures: Patient Care Equipment: Bassinets	05/16/2018			
12	Cleaning Procedures: Patient Care Equipment: Isolettes	05/16/2018			
13	Cleaning Procedures: Patient Care Equipment: Patient Beds	05/16/2018			
14	Cleaning Procedures: Patient Care Equipment: Video Terminal Monitors	05/16/2018			
15	Cleaning Procedures: Patient Care Equipment: Cribs	05/16/2018			
16	Cleaning Procedures: Room/Building Componets: Baseboards	05/16/2018			
17	Cleaning Procedures: Room/Building Componets: Carpet Cleaning	05/16/2018			
18	Cleaning Procedures: Room/Building Componets: Ceilings	05/16/2018			
19	Cleaning Procedures: Room/Building Componets: Dust Mopping	05/16/2018			

Human Resources Policies
May, 2018

1 Dental Insurance and Vision Insurance
2 Benefits as Affected By Changes In Employment Status
3 Leaving Work Area or Premises
4 Work Related Accidents
5 Injury to Patients and Visitors
6 Acceptance of Tips, Gratuities, Rewards, Promotional Gifts or Incentives
7 Address Change
8 Cleanliness and Neatness
9 Information Regarding Patients
10 Unauthorized Hospital Visitors
11 Licenses and Registrations
12 Telephone Use
13 Telephone Courtesy
14 Safety
15 Promotions
16 Transfers
17 Performance Evaluations
18 Reporting Late and Leaving Early
19 Return to Work Following Illness
20 Assignments and Garnishments
21 Conferences with Supervisors
22 Employee Dissatisfaction
23 Termination Benefits
24 Termination
25 Leaving Without Notice
26 Bulletin Boards
27 Lost and Found
28 Security/Safety Program
29 Package Inspections
30 Suggestions

POLICIES TO THE BOD

LABORATORY

POLICY & PROCEDURES TO THE BOARD **MAY - 2018**

LABORATORY

	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**	**P&P UPDATED**
1	Point of Care HemoCue Hb 201+Hemoglobin Testing*	05/16/2018			
2	Hemosure - One Step Immunological Fecal Occult Blood Test*	05/16/2018			
3	Urine Dipstick Chemistries - Chemstrip 10UA*	05/16/2018			
4	Training and Competency in Fern Testing	05/16/2018			
5	Point of Care QuickVue Dipstick Strep A Test *	05/16/2018			
6	Training and Competency in Point of Care Testing*	05/16/2018			
7	Point of Care QuickVue hCG Urine Test*	05/16/2018			
8	Hemoccult Sensa Fecal Occult Blood*	05/16/2018			
9	Provider-Performed Microscopy Competency*	05/16/2018			

NOTE:

These have been reviewed and revised all POC P&Ps for 2018 (exception Accu-Chek policy: needs revision after Peri/Peds committee). Dr Wasef has signed all minor revisions as of today 5/7/2018.

Policies with no changes:
- Hemoccult Sensa Fecal Occult Blood Test
- Hemosure One-step Immunological Fecal Occult Blood Test
- Urine Dipstick Chemistries – Chemstrip 10 UA

Policies with minor changes (V.2 = Version 2):
- HemoCue Hb201+ Hemoglobin Testing
- QuickVue hCG Urine Test
- QuickVue Dipstick Strep A Test
- Provider-performed Microscopy Competency
- Training and Competency in Fern Testing
- Training and Competency in Point of Care Testing

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

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

TO: NIHD Board of Directors
FROM: Richard Meredick, MD, Chief of Medical Staff
DATE: May 7, 2018
RE: Medical Executive Committee Report

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

A. Policies/Procedures/Protocols/Order Sets (*action items*)
    1. *Code Blue Procedure – Code Blue Team*
    2. *Color-Coded Wristband Use*
    3. *Evaluation and Medical Screening of Patients Presenting to the Emergency Department*
    4. *Laser Safety*
    5. *Leaving Hospital Against Medical Advice, Refusal of Treatment or Transfer*
    6. *Management of the Behavioral Health Patient (5150 and non-5150)*
    7. *Medical Screening Examination for Emergency Department Physician Assistant – Standardized Protocol*
    8. *Medical Waste Management*
    9. *Medication/Solution Transfer to the Sterile Field*
    10. *Nursing Care Guidelines in the PACU*
    11. *Preoperative Preparation and Teaching*
    12. *Standards of Care PACU*

B. Annual Review (*action items*)
    1. Surgical Critical Indicators 2018
    2. Anesthesia Critical Indicators 2018
    3. Perinatal Critical Indicators 2018
    4. Neonatal Critical Indicators 2018 (new)

C. OB/GYN Core Privilege form update (*action item*)

D. Interim Chief of Radiology appointment (*action item*)

E. Medical Staff Appointments/Privileges (*action items*)
    1. Steve N. Dong, MD (*Urology*) – Provisional Consulting Staff
    2. Sheldon M. Kop, MD (*Radiology, Tahoe Carson Radiology*) – Consulting Staff
    3. Ian K. Tseng, MD (*Teleradiology, Quality Nighthawk*) – Telemedicine Staff
    4. Rainier A. Manzanilla, MD (*interventional cardiology*) – Provisional Consulting Staff

F. AHP Privileges (*action item*)
    1. Jennifer Figueroa, PA-C – approval to function under the following standardized protocol: *Medical Screening Examination for Emergency Department Physician Assistant*

G. Telemedicine Staff Appointment/Privileges – Proxy Credentialing (*action item*)
As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions.
    1. Zarmen Israelian, MD (*Endocrinology*) – Adventist Health, Telemedicine Staff

H. Medical Staff Resignations (*action item*)
    1. John Williamson, MD (*Renown Telecardiology*) – effective 1/19/18

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Code Blue Procedure - Code Blue Team	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU/CCU, Medical/Surgical, OB/Gyn, Outpatient, PACU, Surgery
Source: Resuscitation Committee	**Effective Date:** 6/15/2014

PURPOSE:

The primary goal of the Code Blue Team is the immediate treatment of the patient in cardiopulmonary arrest. This team will respond to an announced Code Blue that occurs anywhere in the hospital building.
The Code Blue Team shall consist of the Emergency Department (ED) physician, Respiratory Therapist, and four members of the nursing staff who are selected by the Nursing Supervisor at the beginning of each shift.

POLICY:

1. The Emergency Department physician shall be the Code Blue team leader.
2. Any cardiac arrests in the operating room will follow the **Cardiac Arrest in the OR** Policy. The House Supervisor will be notified of cardiac arrests in the OR.
3. A Code Blue Critique will be completed after every Code Blue by the RN Leader and House Supervisor.
4. All codes will be peer reviewed as a critical indicator for the Emergency Department and will be reviewed in the Resuscitation Committee.
5. A copy of the Code Blue Critique will be sent to the Performance Excellence Department.
6. Advanced Directives and Physician Orders for Life Sustaining Treatment (POLST) will be reviewed and communicated to the Code Blue Team Leader as soon as possible.
7. The Code Team will be posted daily and changed as needed on the hospital intranet by the House Supervisors.

PROCEDURE:

<u>RN CODE LEADER:</u>
RN Leader will be filled by the ED RN. If the patient is in the ICU, then the primary nurse will be the RN Leader. Qualifications: ED or ICU RN with current ACLS and PALS certification.
Performs or delegates the following:

1. Coordinates team members and treatment. Ascertains physician in charge and receives orders directly from that physician.
2. Insures that all Basic Life Support is delivered per latest American Heart Association standards, including proper rate and depth of compressions, adequate changes in compressor role, and quick resumption of CPR after interventions or pulse checks.
3. Follows ACLS and PALS algorithms and performs cardioversion, pacing, defibrillation, monitors patients and administers drugs as per Medical Staff orders. All procedures, treatments, and medications will be carried out per order of the physician, with the use of closed loop communication.
4. All procedures, treatments, and medications will be communicated to the recorder to insure complete and timely documentation.
5. Insures that noise and unnecessary conversations are kept to a minimum.
6. Work with House Supervisor during resuscitation to release staff that are not needed.

draft

Title: Code Blue Procedure - Code Blue Team	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU/CCU, Medical/Surgical, OB/Gyn, Outpatient, PACU, Surgery
Source: Resuscitation Committee	**Effective Date:** 6/15/2014

7. Insures notification of family and makes sure Social Worker, Case Manager or staff member is assigned to family if present during the resuscitation.

STAFF CODE ASSIST RN :

1. Positions bed and removes head board. .
2. Brings crash cart to the bedside. Crash carts are located in ED Rm.1 and 7, ICU, Acute/Subacute, PACU, OR, CT scan, and Cardiopulmonary Department.
3. Applies fast patches and/or monitor leads from the Philips MRX monitor.
4. Runs initial monitor strip
5. Assist with any additional procedures as needed.
6. Insert NG tube or delegate
7. Insert Foley catheter or delegates
8. Set up Central Line Trays as needed or prepares EZ-IO for physician.
9. Insures that Vital Signs are done every 5 minutes if BP and pulse present.

CODE COMPRESSIONS:

Nurses Assistant, Unit Clerk, RN, LVN, Ancillary Department Staff.
Qualifications: Current BLS card with no medical restrictions for performing CPR.

1. Places backboard under patient. This can be found on the back of the crash cart.
2. Takes over cardiac compressions. This requires frequent changes with no person performing compression for longer than 2 minutes at a time. This is to insure good quality compressions are maintained and to avoid fatiguing staff.

CODE RECORDER:

Recorder may be the nursing supervisor, ED RN, or ICU RN. No staff will be assigned to this position if they do not maintain a current ACLS and PALS certification.

1. Recorder - records all information during code on code sheet
2. Accurately times start of Code and all treatments.
3. Charts VS Q 5 min. when BP and pulse present or insures that an electronic record of vital signs is maintained.
4. Prompts Code I for appropriate ACLS and PALS protocols.
5. Sees that Quality Review Report and code critique are completed and routed to Performance Improvement

RESPIRATORY THERAPIST:

1. Manages airway and ventilations.
2. Manages and secures endotracheal tube.

3. Monitor SpO_2, and $ETCO_2$ on all patients in a resuscitation.
4. Assist with transport for procedure or transfer.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Code Blue Procedure - Code Blue Team	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU/CCU, Medical/Surgical, OB/Gyn, Outpatient, PACU, Surgery
Source: Resuscitation Committee	**Effective Date:** 6/15/2014

REFERENCE:
1. American Heart Association: Advanced Cardiac Life Support

CROSS REFERENCE:
1. Code Blue Documentation
2. Cardiac Arrest in the Operating Room

Committee Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
Resuscitation Committee	
MEC	5/7/18
Board of Directors	
Last Board of Director review	6/21/17

Revised: 3/98; 02/01 JK; 12/03, 06/11AS, 7/14 AS, 04/2018 gr

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

Draft

1. Purpose

To have a standardized process that identifies and communicates patient-specific risk factors or special needs by using color-coded wristbands based upon the assessment of the patient, the patient's wishes and medical status.

2. Objectives

   A. To reduce confusion associated with the use of color-coded wristbands by using colors standardized throughout California.
   B. To communicate patient-safety risks to all health care providers.
   C. To include the patient, family members and significant others in the communication process and promote safe care.
   D. To adopt the following risk-reduction strategies:
      1. A preprinted written descriptive text is used on the bands, clarifying the intent (e.g., "Allergy," "Fall Risk" or "DNR").
      2. No handwriting is used on the wristbands.
      3. Color-coded wristbands may only be applied or removed by a nurse conducting an assessment.
      4. If labels, stickers or other visual cues are used in the medical record to communicate risk factors or wristband application, those cues should use the same corresponding color and text as the color-coded band.
      5. Social (community) cause (social cause wristbands include, for example, "LIVESTRONG") wristbands should not be worn by patients in the hospital. Staff should have family members take the social cause wristbands home, or remove them from the patient and store them with their other personal items. This is to avoid confusion with the color-coded wristbands and to enhance patient-safety practices.
      6. When a color-coded wristband is applied, the patient and family are educated regarding the wristband message.

3. General Policies

Colors used for wristbands. The following represents the only color-coded wristbands used:

   A. Clear wristbands shall be used for patient identification. The patient identification and admission identification bands may be applied by non-clinical staff in accordance with hospital policy.
   B. Purple wristbands shall be used to identify patients with a "Do Not Resuscitate" order written in the medical record in accordance with hospital policy. The letters "DNR" shall be embossed/printed on the wristbands.
   C. Red wristbands shall be used to identify patients with allergies. The list of allergies should be written in the medical record in accordance with hospital policy. Allergies should include allergies to medication(s), food, environmental allergens

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

or other substances that may cause an allergic reaction in the patient. The letters "ALLERGY" shall be embossed/printed on the wristband.

D. Yellow wristbands shall be used to identify patients with a risk of falling. Persons with a risk of previous falls, dizziness or balance problems, fatigability or confusion about their current surroundings should be assessed for potential fall risk. The letters "FALL RISK" shall be embossed/printed on the wristband.
E. Green wristbands shall be used to identify patients with sepsis. This shall be applied when the patient meets the SOFA criteria. The letters "SEPSIS" shall be embossed/printed on the wristband.

Application of color-coded wristbands. During the initial and reassessment procedures, allergies, DNR status and risk factors associated with falls may be identified. Assessment of potential risk is an interdisciplinary process

A. The nurse performing the assessment is authorized to determine fall risk and patient allergies as determined by the assessment, and place the appropriate color–coded wristband on the patient. Only the nurse performing the patient assessment is designated to apply or remove color-coded wristbands. Color-coded wristbands should be used for all patients with these conditions, including all inpatient and emergency department patients
B. The determination of a "Do Not Resuscitate" order must be consistent with hospital policy and must be documented in the patient's medical record prior to the nurse placing the DNR wristband on the patient.
C. Handwriting is not permitted on color-coded wristbands.
D. It should be documented in the patient's medical record that a color–coded wristband was applied, for specific reasons (i.e. Risk Fall, DNR and/or Allergy. **[DO NOT DOCUMENT WRISTBAND COLOR.]**
E. All color-coded wristbands shall be placed on the same wrist as the patient identification wristband.
F. Upon application of the color-coded wristband, the nurse shall instruct the patient and family member(s), if present, that the wristband is not to be removed.
G. In the event that any color-coded wristband(s) must be removed for a treatment or procedure, a nurse will remove the wristband(s). Upon completion of the treatment or procedure, risks shall be reconfirmed and new wristband(s) immediately applied by the nurse.

4. "Social (Community) Cause" Wristbands
   The nurse shall examine the patient for "social (community) cause" wristbands, during the initial assessment. If "social cause" wristbands are present, the nurse will explain the risks associated with the wristbands and ask the patient to remove them. If the patient agrees, the band(s) will be removed and given to a family member to take home, or stored with the patient's personal belongings. If the patient

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refuses to remove the "social cause" wristband, the nurse will request that the patient sign a refusal form acknowledging the risks associated with the "social cause" wristbands (see attached document).

5. Patient/Family Involvement and Education
   Staff should assist and encourage the patient and family member(s) to be active partners in the care provided and safety measures being used. The nurse should teach all patients and family members to notify the nurse whenever a wristband has been removed and is not reapplied, or when a new band is applied and they have not been given an explanation as to the reason.

   When applying a color-coded wristband(s) to a patient, the nurse shall educate the patient and family member(s) about the meaning of the wristband(s) applied, risks associated with wearing social cause wristbands in the hospital, and their role in color-coded wristbands. During assessment of the patient, the nurse shall educate and re-educate the patient and family members about the meanings of the color-coded wristband(s) applied, the risks associated with wearing social cause wristbands and why they are asked to remove them, and to notify the nurse if color-coded wristband condition(s) have changed.

6. Hand–Off in Care
   The nurse shall reconfirm that the color-coded wristbands are consistent with the documentation in the medical record before invasive procedures, at transfer and during changes in level of care. The nurse shall also confirm this information is consistent with the knowledge of the patient, family members or other caregivers and what is in the patient's chart. Errors are corrected immediately.

   Color-coded wristbands are not removed at discharge. For home discharges, the patient is advised to remove the band at home. For discharges to another facility, the wristbands are left intact as a safety alert during transfer. Receiving facilities should follow their policy and procedure for the banding process.

7. DNR (Do Not Resuscitate)
   The DNR color-coded wristband serves as an alert and does not take the place of an order. DNR orders must be written and verification of advanced directives must occur.

8. Staff Education
   Staff education regarding color-coded wristbands will occur during the new orientation process and updated with any changes to this policy.

9. Patient Refusal
   If the patient is mentally competent and refuses to wear the color-coded wristband, an explanation of the benefits of wearing the color-coded wristband and the risks of not wearing the wristband will be provided to the patient. The nurse will reinforce that this is an opportunity to participate in efforts to prevent errors, and it is his/her responsibility as part of the team. The nurse will document in the medical record patient refusals, and the explanation provided by the patient. The patient will be requested to sign a *Patient Refusal to Participate in the Wristband Process* form.

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Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

10. Surrogate Decision-maker
    If the patient is not mentally competent, the appropriate surrogate decision-maker will be consulted according to hospital policy.

REFERENCES:

1. TJC CAMCAH 2016, PC.01.02.08
2. TJC CAMCAH 2016, PC.01.03.01
3. CAH State Operations Manual 12/2016, CFR 489.012

CROSS REFERENCE P&P:

1. Advanced Directives
2. Fall Risk Prevention – Perinatal
3. Fall Prevention and Management
4. Sepsis, Emergency Patient Care (Lippincott)

Approval	**Date**
CCOC	
Medical Services/ICU Committee	4/26/18
Perinatal/Pediatrics Committee	2/23/18
Medical Executive Committee	5/7/18
Board of Directors	
Last Board of Directors Review	

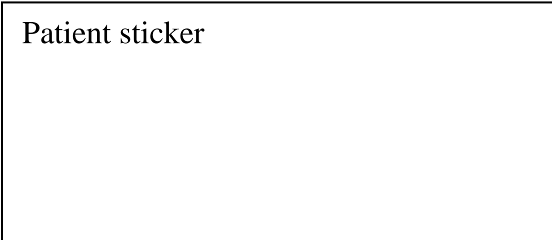
Developed: 12/2008 bss/jk
Reviewed: 3/15 bss
Revised: 5/11 jm; 9/12 bss; 12/17 ta
Supersedes:
Index Listings:

draft

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

NORTHERN INYO HOSPITAL

Patient Refusal to Participate in the Wristband Process


Patient sticker

The above-named patient refuses to (check all that apply):
_____ Wear color-coded wristbands.
A member of the health care team has explained the benefits of the use of color-coded wristbands to me. I understand the benefits of the use of color-coded wristbands and the risks of refusing the wristbands and, despite this information, do not give permission for the use of color-coded wristbands in my care.

_____ Remove “social cause” wristbands (e.g., charity wristbands).
A member of the health care team has explained the risks of refusing to remove the “social cause” wristbands to me. I understand that refusing to remove the “social cause” wristbands could cause confusion in my care and, despite this information, I do not give permission for the removal of “social cause” wristbands.

Reason provided (if any): ____

____

______________________ ____

Date/Time Signature/Relationship

______________________ ____

Date/Time Witness Signature/Job Title

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Evaluation and Medical Screening of Patients Presenting to the Emergency Department**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 5/20/2004

PURPOSE:

To ensure that all patients coming to the hospital requesting emergency services receive an appropriate Medical Screening Examination as required by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C., Section 1395 and all Federal regulations and interpretive guidelines promulgated there under.

DEFINITIONS:

1) **Medical Screening Examination (MSE)** is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility's capabilities and available personnel, including on-call physicians. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and continue until the patient is either stabilized or appropriately transferred.
2) **Qualified Medical Personnel (QMP)** is a provider that is qualified to perform the MSE. The default QMP in the emergency department is the ER physician. The patient's primary physician (PMD) can perform an MSE if desired and if immediately available. A Physicians Assistant (PA) with specific training in accordance with the "TRAINING OF PHYSICIAN ASSISTANT AS QUALIFIED MEDICAL PERSONNEL IN THE EMERGENCY DEPARTMENT" policy may also perform the MSE in the emergency department.

POLICY:

1) All persons seeking treatment will be evaluated by a triage RN to determine chief complaint and to determine acuity according to Emergency Severity Index (ESI) level.
2) OB patients will be treated in accordance with the "EVALUATION OF PREGNANT PATIENTS IN THE EMERGENCY DEPARTMENT" policy.
3) A QMP will evaluate and perform a medical screening examination, which will include:
   a. History
   b. Physical exam of affected systems
   c. Physical exam of potentially affected systems and known chronic conditions
   d. Any testing necessary to rule out the presence of legally defined emergency medical conditions (lab, x-ray, CT, etc.)
   e. Use of on-call personnel if needed. to complete above
   f. Use of on-call physicians if needed to diagnose and stabilize the patient
   g. Discharge/transfer vital signs
   h. Documentation of all aspects of the Medical Screening Examination
4) ~~The patient's primary physician (PMD) may perform the medical screening exam in the hospital.~~
5) ~~The ER physician will perform the medical screening exam for any patient needing immediate treatment unless the PMD is immediately available.~~
6) All persons seeking treatment in the Emergency Room for an emergent condition will have a medical screening examination completed without consideration of their ability to pay for services.

Committee Approval	Date
CCOC	10/23/17
Emergency Services Committee	4/30/18

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Evaluation and Medical Screening of Patients Presenting to the Emergency Department**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 5/20/2004

Medical Executive Committee	5/7/18
Board of Directors	
Last Board of Director review	6/21/17

Revised 10/2017gr

Reviewed 6/11as; 2/15as; 4/18 sb
Supersedes

References:

1. EMTALA: A Guide to Patient Anti- Dumping Laws (2009)

Cross Reference P & P

1. Emtala Policy
2. Triage
3. Medical Screening Examination for Obstetrical Patient

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Laser Safety	
Scope: PACU, Surgery	Manual: PACU, Surgery
Source: DON Perioperative Services	Effective Date:

Purpose

To provide guidance to perioperative personnel for the use and care of laser equipment and to assist practitioners in providing a safe environment for patients and health care personnel during the use of laser technology. The expected outcome is that the patient will be free from signs and symptoms of injury related to the use of laser technology.

Policy

- A laser safety program will be established for all owned, leased, or borrowed laser equipment in any location where lasers are used in the health care organization. The program will include:
    - delegation of authority for supervising laser safety to a laser safety officer (LSO) responsible for:
        - verifying the manufacturer's hazard classification label of all lasers and laser systems;
        - performing a laser hazard evaluation before initial use;
        - overseeing the implementation of the health care laser system manufacturer's control measures;
        - developing policies and procedures for maintenance, service, and use of lasers;
        - verifying that protective equipment is available, used correctly, and free of defects;
        - ascertaining that warning signs and labels comply with the Federal Laser Product Performance Standard or international standards;
        - approving equipment and installation according to the manufacturer's instructions; and
        - coordinating laser safety and educational programs;
    - establishment of a multidisciplinary laser safety committee that includes the LSO and representatives from administration, medicine, anesthesia, nursing, and risk management;
    - establishment of use criteria and authorized procedures for all health care personnel working in laser nominal hazard zones;
    - identification of laser hazards and appropriate administrative, engineering, and procedural control measures;
    - education of personnel regarding the assessment and control of hazards; and
    - management and reporting of accidents or incidents related to laser procedures, including creating action plans to prevent recurrences.
- All personnel will know where lasers are being used, and access to these areas will be controlled.
- Patients and personnel in the laser treatment area will be protected from unintentional laser beam exposure.
- All people in the nominal hazard zone will wear appropriate eyewear selected and approved by the LSO.
- Potential hazards associated with surgical smoke generated in the laser practice setting will be identified and safe practices established.
- All people in the laser treatment area will be protected from electrical hazards associated with laser use.
- All people in the laser treatment area will be protected from flammable hazards associated with laser use.

Procedure Interventions

- The laser treatment area will be identified with laser warning signs and access controlled to prevent unintentional exposure to the laser beam.

Title: Laser Safety	
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Source: DON Perioperative Services	Effective Date:

  - The LSO will determine the nominal hazard zone by referencing ANSI Z136.1 and ANSI Z136.3, as well as the safety information supplied by the laser manufacturer.
  - Clearly marked and recognizable warning signs specific to the type of laser being used and designed according to the information described in ANSI Z136.3 will be placed at all entrances to laser treatment areas when lasers are in use.
  - Doors in the nominal hazard zone will remain closed and windows, including door windows, will be covered as appropriate to the type of laser being used with a barrier that blocks transmission of a beam.
- Accidental activation or misdirection of the laser beam will be prevented by
  - restricting access to laser keys to authorized personnel who are skilled in laser operation;
  - placing lasers in standby mode when not in active use;
  - placing the laser foot switch in a position convenient to the operator with the activation mechanism identified;
  - allowing only the laser user to activate the foot pedal of the laser device;
  - using the emergency shutoff switch to disable the laser in case of a component breakdown or untoward event; and
  - protecting exposed tissues around the surgical site with saline-saturated materials (eg, towels, sponges) when lasers with a thermal effect are being used.
- The laser assistant (eg, RN, laser technician) must not have competing responsibilities that would require leaving the laser unattended during active use.
- Everyone in the nominal hazard zone will wear protective eyewear or use filters of specific wavelength and optical density for the laser in use.
  - Eyewear will be labeled with the appropriate optical density and wavelength for the laser in use.
  - Laser shutters or filters with the appropriate optical density will be used on microscopes, microscope accessory oculars, and endoscope viewing ports to protect the laser user from laser exposure.
  - Patients' eyes and eyelids will be protected from the laser beam.
    - Patients who remain awake during laser procedures will wear goggles or glasses designated for the type of laser being used.
    - Patients undergoing general anesthesia will be provided with appropriate protection, such as wet eye pads or laser-specific eye shields, as approved by the LSO.
    - Patients undergoing laser treatments on or around the eyelids will have their eyes protected by metal corneal eye shields that are approved by the US Food and Drug Administration (FDA).
- Surgical smoke will be removed by use of a smoke evacuation system in both open and minimally invasive procedures to prevent occupational exposure to laser-generated airborne contaminants.
  - When surgical smoke is generated, an individual smoke evacuation unit with a 0.1 micron filter (eg, ultra-low particulate air [ULPA] or high-efficiency particulate air [HEPA]) will be used to remove surgical smoke.
  - The capture device (eg, wand, nonflammable suction tip) of the smoke evacuation system will be positioned as close as possible, but no greater than two inches, from the source of the smoke.
  - Used smoke evacuator filters, tubing, and wands will be handled using standard precautions and disposed of as biohazardous waste.
  - Personnel will wear respiratory protection (eg, fit-tested surgical N95 filtering face piece respirator or high-filtration surgical mask) during procedures that generate surgical smoke.
- Laser systems and equipment will be evaluated for electrical hazards and approved by the LSO before they are placed in service.

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- The manufacturer's directions for laser installation, operation, and maintenance and recommendations for electrical plugs and outlets will be followed.
- Laser service and preventive maintenance will be performed in accordance with the manufacturer's guidelines on a regular basis by qualified personnel who have knowledge of laser systems.
- Fire safety measures will be implemented when lasers are in use according to local, state, and federal regulations.
  - The laser will not be activated in the presence of flammable agents (eg, alcohol-based skin antiseptics, tinctures, de-fatting agents, collodian, petroleum-based lubricants, phenol, aerosol adhesives, uncured methyl methacrylate) until the agents are dry and vapors have dissipated.
  - Caution will be used in the presence of combustible anesthetic gases during surgery on the head, face, neck, and upper chest.
  - Sponges and drapes near the surgical site will be kept moist.
  - The lowest possible oxygen concentration that provides adequate patient oxygen saturation will be used.
  - Surgical drapes will be arranged to minimize the buildup of oxidizers (eg, oxygen, nitrous oxide) under the drapes.
  - Wet towels and saline will be available on the sterile field.
  - The LSO will determine the type of extinguishers needed for each specific laser based on manufacturers' instructions and recommendations.
  - Laser-resistant endotracheal tubes will be used during laser procedures involving the patient's airway or aerodigestive tract.
  - Endotracheal tube cuffs will be inflated with normal saline with dye (eg, methylene blue) during laser procedures involving the patient's airway or aerodigestive tract.
  - Moistened packs will be placed around the endotracheal tube and kept moist throughout the procedure.

Documentation

Documentation will be completed to demonstrate compliance with local, state, and federal regulations.

- The following information will be documented in the perioperative record by the perioperative RN:
  - patient identification;
  - the type of laser used (eg, wavelength, serial or biomedical number);
  - laser settings and parameters;
  - safety measures implemented during laser use;
  - the operative or invasive procedure;
  - on/off laser activation and de-activation times for head, neck, and chest procedures; and
  - patient protection (eg, eyewear, eye shield).
- A laser safety checklist will be completed by the laser assistant and will include:
  - performing a laser self-test check before the patient is brought into the OR or procedure room,
  - calibrating the laser if needed,
  - conducting a test fire of the laser,
  - posting "laser in use" signs at all entrances of the OR or procedure room,
  - providing appropriate eyewear for the patient and personnel,
  - covering the windows of the OR or procedure room as needed,
  - checking the availability of saline at the surgical field, and
  - checking the appropriate type of fire extinguisher for the laser being used.
- The following information will be documented in the laser log by the laser assistant:
  - patient identification;

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  - the type of laser, model number, serial number, and the health care organization-biomedical number;
  - the procedure(s) performed with laser;
  - names and titles of personnel in the room;
  - completed laser safety checklists;
  - the number of joules used;
  - the total energy used; and
  - the wattage used.

Competency

- Perioperative personnel working in laser environments will receive education and complete validation activities on laser systems used and procedures performed in the facility, including:
  - the established laser safety program;
  - new laser equipment, accessories, or safety equipment purchased or brought into the facility; and
  - fire hazards associated with laser use, airway fire management, and fire drills.
- The LSO will complete a formal medical laser safety course and obtain certification.

Glossary

American National Standards Institute (ANSI): Organization that provides guidance for the safe use of lasers for diagnostic and therapeutic uses in health care facilities. ANSI facilitates the development of consensus US standards and administers a system that assesses conformance to standards such as the ISO 9000 (quality) and ISO 14000 (environmental).

High-efficiency filter or *high-efficiency particulate air filter (HEPA):* Filters having a filtration rating of 0.3 microns at 99.7% efficiency.

Laser: Device that produces an intense, coherent, directional beam of light by stimulating electronic or molecular transitions to lower energy levels. Laser is an acronym for “light amplification by stimulated emission of radiation.”

Laser assistant: Sets up the laser and runs the laser console to control the laser parameters under the supervision of the laser user.

Laser safety officer (LSO): Responsible for affecting the knowledgeable evaluation of laser hazards and authorized and for monitoring and overseeing the control of such laser hazards.

Laser treatment area: Area in which the laser is being operated.

Laser user: The laser user is employing the laser for its intended purpose within the user’s scope of practice, education, and experience.

Nominal hazard zone: The space in which the level of direct, reflected, or scattered radiation used during normal laser operation exceeds the applicable maximum permissible exposure.

Optical density: The ability of laser protective eyewear to absorb a specific laser wavelength.

Ultra-low particulate air (ULPA) filter: Theoretically, a ULPA filter can remove from the air 99.9999% of bacteria, dust, pollen, mold, and particles with a size of 120 nanometers or larger.

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Laser Safety	
Scope: PACU, Surgery	Manual: PACU, Surgery
Source: DON Perioperative Services	Effective Date:

References

1. Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2010.
2. Recommended practices for laser safety in perioperative practice settings. In: *Perioperative standards and Recommended Practices*. Denver, CO: AORN, Inc: 2013:143-156.
3. Z136.3-2005: *Safe Use of Lasers in Health Care Facilities*. Washington, DC: American National Standards Institute; 2005.
4. Z136.1-2007: *Safe Use of Lasers*. Washington, DC: American National Standards Institute; 2007.

CROSS REFERENCE P&P:

1. Laser Safety

Approval	**Date**
CCOC	3/25/18
STTA	4/25/18
MEC	5/7/18
Board of Directors	
Last Board of Director review	

Developed: 2/18
Reviewed:
Revised:
Supersedes:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	**Department:** District Wide
Source: Emergency Dept Nurse Manager	**Effective Date:**

PURPOSE:
To provide a process for when a patient leaves against medical advice or refuses a treatment or transfer.

POLICY:
An individual, except patients under police guard or an involuntary hold, has the right to leave the hospital against the advice of his physician. Any individual who has received treatment at NIH and then refuses further care or transfer will be informed of the benefits of further care versus the risk of no further care.

PROCEDURE:

A. If a patient, for any one of many reasons, desires to leave the hospital before his doctor thinks he is ready for discharge, refuses a certain treatment, test or intervention ordered, or transfer to another facility, every effort must be made to convince the patient to remain in this hospital or proceed with the tests/treatment or transfer.
1. Notify physician of the situation.
    a. The physician must attempt to provide the patient with information regarding the risks involved in leaving, benefits of continued stay in the hospital, and any other alternatives such as transfer to another facility or any other treatment.
2. Patient's cause for discontent must be ascertained and solved if possible.
3. Efforts should be also be made by the RN and shift supervisor to convince the patient to change his/her mind and all risks must be explained to the patient. This shall be well documented on the nurse's notes by the RN or shift supervisor.
4. Patient's family and friends who may be concerned for his well-being should be enlisted to convince him to stay.

B. When all efforts have been made and the patient (or individual acting on their behalf) is still adamantly refusing further treatment and/or transfer and/or insists on leaving against medical advice, the informed refusal will be documented in writing on the appropriate form: (Available in English and Spanish)
1. *Informed Consent to Refuse Treatment*
2. *Leaving the Hospital Against Medical Advice*
3. *Patient Refusal of Transfer*

C. No patient, other than patients under police guard or on involuntary psychiatric holds, can be forced physically to stay in the hospital against their will.

D. If a patient leaves undetected without signing the appropriate form, hospital staff should attempt to locate him/her and request that he/she return to the hospital so his /her signature may be secured on the form. Document all attempts and the results on the patient's chart.

E. Notify the following of AMA:
a. Physician
b. House Supervisor
c. Department Manager

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	**Department:** District Wide
Source: Emergency Dept Nurse Manager	**Effective Date:**

d.. Director of Nursing, if appropriate
e. Police, if appropriate
f. Administration, if appropriate

E. If all efforts to return the patient are unsuccessful and he/she cannot be located, document fully and precisely on nurse's notes and make out a Quality Review Report and turn in to Department Manager or House Supervisor.

F. Regardless of whether it is believed the patient will sign or not, the release form must be offered to the patient (or the parent or guardian) for signature in the presence of at least one witness. It is a requirement that this procedure is followed:

1. If the patient (or parent or guardian) refuse to sign, proceed as follows:

a. In the space provided for the patient's signature, write the words "***patient refuses to sign***." Beneath this line, sign your name and enter the exact time, date and a brief notation concerning the circumstances of the refusal.
b. All hospital personnel who were present when the release was offered, and refused, must sign as witnesses to the refusal. Each witness must write his/her complete name - no initials.

REFERENCE:

1. California Hospital Association Consent Manual (2014), Ch. 5.5, Ch.9.2
2. California Code of Regulations Title 22 (2011), Article 70707, Patients Rights

CROSS REFERENCE:

1. 28-03 Patients Rights, Patients Responsibilities and Process for Resolution of Patient Grievances or Complaints.

Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
Medical Services/ICU	4/26/18
Peri-Peds	2/23/18
STTA	4/25/18
MEC	5/7/18
Board of Directors	

Revised/Reviewed: 12/96; 9/00; 2/01; 7/11as; 2/15as
Last Board of Director review: 6/21/17

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Management of the Behavioral Health Patient (5150 and non-5150)	
Scope: Hospital	Manual: Social Services
Source: Licensed Clinical Social Worker	Effective Date:

PURPOSE:

A. To provide a safe, private and confidential environment for the treatment of adult and pediatric patients with psychiatric concerns who require acute medical, surgical and/or maternal-child care.

B. To provide guidelines for care of patients on 5150 hold, at risk for suicide, or with psychiatric disorders, and to appropriately manage interventions, minimizing the risk of further self-harm or harm to others.

C. To provide an assessment tool for risk stratification of the potentially suicidal patient by the non-psychiatric professional.

DEFINITIONS:

A. **Welfare and Institutions Code Section (WIC) 5150**: When any adult, as a result of a mental disorder, is a danger to themselves or other, or gravely disabled, a peace officer or a professional designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her into a designated facility for psychiatric evaluation and treatment.

B. **WIC 5585**: Civil commitment as above applied to minors.

C. **Minor**: Any individual under the age of 18 who is not married or divorced, currently in active military duty or legally emancipated.

D. **DTS-Danger to Self**: As a result of a mental disorder, the person may be suicidal or express significant harm to him or herself.

E. **DTO-Danger to Others**: As a result of a mental disorder, the person expresses harm to others or demonstrates a reckless disregard for the safety of others.

F. **GD-Gravely Disabled Adult**: As a result of a mental disorder, the person is not able to provide for the basic needs of food, clothing, shelter, or to voluntarily utilize such provisions when they are offered.

G. **GD-Gravely Disabled Minor**: A person 17 years old or younger who, as a result of a mental disorder, is unable to utilize the elements of life which are essential to health, safety, and development including food, clothing, or shelter even though provided to the minor by others.

WIC 5150/5585 HOLD FOR TRANSPORT

A. Patients that are a danger to themselves or others, or who are gravely disabled, may be detained without consent while transfer arrangements are being made.

B. Meeting the WIC 5150/5585 criteria and with probable cause, the person may be taken into custody and transported to a facility designated as a facility for 72-hour treatment and evaluation of mental disorders.

C. The code section defines peace officer as having the authority to write as WIC 5150. In addition, Inyo County Behavioral Health designates personnel who are authorized to place a 5150 hold.

1. Patients presenting to the hospital will be triaged by a nurse and seen by the physician upon arrival. Necessary precautions will be taken, as the nurse will follow the policy and procedure as instructed in the procedure portion of this policy.

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2. The patient must first be medically cleared by the physician prior to calling Behavioral Health on call staff. This may include labs such as toxicology tests to rule out substance abuse, ETOH, Tylenol levels, Aspirin levels, Urinalysis, and any other medical tests deemed necessary by the physician. Behavioral Health professionals are not able to evaluate patients that are altered due to drug or alcohol intoxication.

3. Contact designated Behavioral Health on call staff to evaluate patient and assist in placement (after patient is medically cleared).

4. Contact the hospital Social Worker Monday-Friday from 0800-1700.

5. The designated Behavioral Health professional will perform an assessment as soon as the patient's condition permits. The risk assessment will include collaborative information from a parent and/or guardian or other persons with relevant information as the situation allows. A written plan will be included as part of the assessment indicating risk factors, recommendations for disposition, including transfer to an inpatient treatment facility, further evaluation, or discharge home with appropriate outpatient linkages to community programs and resources.

6. If a patient communicates a threat involving a third party, the physician, registered nurse, or the Behavioral Health professional will follow relevant legal and ethical guidelines regarding privacy of information and duty to warn third parties (California Civil Code 43.92).

7. After risk assessment, the Behavioral Health professional or Peace Officer will decide if the patient meets WIC 5150/5585 criteria. If the patient meets criteria, a hold will be placed.

8. If the patient is not able to be placed in a designated inpatient psychiatric facility within the 72 hour hold period, the Behavioral Health professional must re-assess the patient and decide if the patient continues to meet criteria to be placed on another 72-hour hold or be released.

9. Behavioral Health, in coordination with Northern Inyo Hospital staff will identify and coordinate placement and transportation, keeping in contact with hospital staff for any necessary consultation or aide during the placement process.

10. The Behavioral Health professional may remove the hold if the person is determined to be safe and can be discharged home.

11. High risk patients not yet placed on a WIC 5150/5585 hold are an escape risk and yet may be medically cleared. Notify local law enforcement if the patient intends to leave AMA. A "medical hold" pursuant 1799.111 W&I may be applied for 24 hours pending a Behavioral Health evaluation.

POLICY:

A. All care will be delivered in a respectful and dignified manner utilizing safety measures to care for the adult and pediatric patient in a safe environment for both the patient and staff.

B. Northern Inyo Hospital recognizes the acute medical needs of the potentially suicidal patient by providing compassionate care utilizing evidence based practice assessment tools and interventions to prevent the patient from further self harm or harm to others.

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C. Northern Inyo Hospital has limited capabilities in providing psychiatric services and will therefore provide immediate emergent services, interventions (including admission for stabilization), assessment and appropriate referrals to those requiring psychiatric services. Transfer of the patient may be required after acute medical services are completed in order to continue further psychiatric treatment in an appropriate level of care.

1. Patients with psychiatric concerns who require medical, surgical and/or maternal-child care may be admitted to the appropriate unit to meet their current healthcare needs.
2. Medically unstable patients assessed as having the potential to harm self and/or others will be provided continuous observation until medically stable and a psychological evaluation can be performed to determine the appropriate intervention required. Patients who are designated as meeting WIC 5150/5585 criteria prior to admission to the hospital will be provided continuous observation upon admission until an assessment can be performed to determine the patient’s needs.
3. Northern Inyo Hospital has as approved partner guidelines with Inyo County Behavioral Health to assist with meeting patient’s emergent psychiatric needs. The partners will meet at least quarterly to review for quality assurance/improvement purposes and will update Guidelines as necessary to provide optimal care for the patient.

PROCEDURE ED/ INPATIENT DIRECT ADMIT:

1. At a minimum, all patients 13 years of age or older admitted to the hospital with a behavioral health related chief complaint or showing signs/symptoms of self-harm risk will be screened for suicidal risk by a Registered Nurse (RN) using the PSS-3 screen (Attachment A).
2. A positive PSS-3 is defined as yes to any of the questions and warrants a full suicide risk assessment using the C-SSRS Screen Version with Triage Points (Attachment B) found in the electronic assessment record and completed by the primary Registered Nurse (RN). The result of the C-SSRS suicide risk assessment will determine the level of risk and corresponding monitoring and interventions required to maintain patient safety.
3. Refer to response protocol to C-SSRS screening (found at the bottom of the C-SSRS screen document) for recommendations of when to implement safety precautions, immediate notification of Physician, Social, and Behavioral Health on call staff consult.
4. The nursing staff will implement suicide precautions and notify the Physician as soon as possible following the implementation of these precautions, and will document this in the chart.
5. When available, during normal business hours Monday-Friday, the hospital Social Worker will be contacted to consult with these patients.
6. If the patient cannot be assessed upon arrival due to the patient’s medical status, i.e., the patient is unconscious, intubated, intoxicated, or mentally unable to

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respond, the screening will be postponed until the patient can be assessed. The suicide screening process should be performed as soon as the patient's condition permits. Any concerning or contributing history or circumstances that might indicate and increased risk of suicide shall be communicated to all hospital personnel involved in the care of the patient.

7. The patient will be placed in a private room, closest to the nurse's station to ensure privacy and safety when possible. Undress the patient completely placing patient in a hospital gown with snap closures (not ties). If patient is deemed to a risk to self or others, all patient belongings will be taken away, inventoried, placed in a belongings bag, and kept at the nurse's station or area designated by staff.

8. The nursing staff will complete an environmental patient safety check for a patient at risk of suicide initially and at the beginning of every shift. Any risk identified will be removed from the room, evaluate for relocation of the patient or closer observation. Risks include: carts, tubing, sharps, medical equipment, or anything the patient could use to cause self-harm or harm to others.

9. Restrain patient as necessary to prevent further injury (see Restraint Policy).

10. Primary Registered Nurse will provide 1:1 observation until Safety Attendant is at bedside.

11. Contact hospital security as needed.

12. When patient is deemed medically stable and cleared by the physician, contact Inyo County Behavioral Health on call staff to assess if the patient should be placed on a WIC 5150/5585 hold or other safety plan is to be put in place. **(Refer to 5150/5585 HOLD process outlined above)**.

13. If the patient is not medically stable and requires hospitalization, refer to inpatient ER admit procedure outlined below.

14. Patient's home medications will be reviewed and will be provided to the patient per physician orders.

15. Patients will be provided with a regular diet unless otherwise ordered by the physician. All meals provided will follow these procedures:

a. Food items are to be placed on paper plates, cups, or bowls
b. Only plastic utensils will be placed on food tray.
c. No cans or bottles are to be placed on the food tray.
d. Dietary will deliver the meal to the nurse's station.

16. At a minimum, the following information will be provided at discharge to individuals at risk for suicide and their families:

a. Personal Safety Plan (Attachment C)

PROCEDURE INPATIENT ER ADMIT:

1. If the patient cannot be assessed upon admission due to the patient's medical status, i.e., the patient is unconscious, intubated, intoxicated, or mentally unable to respond, the screening will be postponed until the patient can be assessed. The suicide screening process should be performed as soon as the patient's condition permits. Any concerning or contributing history or circumstances that might

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indicate and increased risk of suicide shall be communicated to all hospital personnel involved in the care of the patient.

2. When the patient is deemed medically stable by the Physician, he/she will be assessed for suicide using **ED/INPATIENT DIRECT ADMIT** procedure steps (1-16) listed above.

3. If the patient has already been assessed for suicide by ER staff and determined to be at risk for suicide and/or put on a 5150 Hold by Behavioral Health staff, follow the **ED/INPATIENT DIRECT ADMIT** procedure steps (3-16) listed above.

FOR ALL INPATIENTS:

1. Ongoing suicide risk assessments will take place every 24 hours as part of the daily psychosocial nursing assessment. The physician should be notified of the ongoing screening results if the need for additional precautions based on the assessment revealing an increased level of risk for suicide.

2. Please follow Leaving Hospital Against Medical Advice and Patient Safety Attendant 1:1 Staffing Guidelines policies as needed.

3. Documentation for inpatients found to be at risk for suicide includes:

a. Initial screening for suicidal risk (PSS-3 and C-SSRS)
b. Additional screenings every 24 hours (C-SSRS)
c. Precautions taken to ensure a ligature free environment
d. Patient behavior and daily activities

REFERENCES:

1. Practical Management of the Suicidal Patient in the Emergency Department, Emergency Medicine Reports, (2013)
2. Care of the Psychiatric Patient in the Emergency Department, ACEP Emergency Medicine Practice Committee (2014)
3. Sentinel Event Alert: New Alert Focuses on Suicidal Ideation, The Joint Commission Perspectives, (2016)

CROSS REFERENCE P&P:

1. Patient Restraints (Behavioral and Non-Behavioral)
2. Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
3. Patient Safety Attendant or 1:1 Staffing Guidelines

Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
Medical Services/ICU Committee	4/26/18
Medical Executive Committee	5/7/18
Board of Directors	
Last Board of Director's Review	

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Management of the Behavioral Health Patient (5150 and non-5150)	
Scope: Hospital	Manual: Social Services
Source: Licensed Clinical Social Worker	Effective Date:

Developed: 1/18hf
Reviewed:
Revised:
Supersedes:
Index Listings:

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Examination for Emergency Department Physician Assistant – Standardized Protocol	
Scope: Physician Assistants	Manual: Emergency Department, Medical Staff
Source: Chief of Emergency Room Service	Effective Date:

PURPOSE:
To describe the procedure for training a Physician Assistant (PA) to be a Qualified Medical Personnel (QMP) and to be able to perform the Medical Screening Examination (MSE) of patients presenting to the emergency department. The PA is determined qualified by the Hospital's Medical Staff Bylaws, Rules and Regulations and approved by the Hospital's Governing Board, in compliance with the provisions of the Emergency Medical Treatment Act (EMTALA) 42 U.S.C., Section 1395.

DEFINITIONS:
1. **Medical Screening Examination (MSE)** is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility's capabilities and available personnel, including on-call physicians. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and continue until the patient is either stabilized or appropriately transferred.
2. **Qualified Medical Personnel (QMP)** is a provider that is qualified to perform the MSE.
3. **Physician Assistant (PA)** is licensed by the State of California Department of Consumer Affairs and possesses preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in emergency care, and who has been prepared in a program that conforms to board standards.

POLICY:
1. Requirements for a PA to perform the MSE:
    a. Minimal Education/Training
        i. Be trained and licensed as detailed in the *General Policy for Emergency Department Physician Assistant*.
        ii. Successfully complete the hospital didactic module for performing Medical Screening Examination of the Emergency Patient with 100% accuracy.
            1. Upon completion of this module, the PA will be able to:
                a. List potential consequences of failing to comply with EMTALA
                b. Recognize key features of the medical screening exam (MSE) under EMTALA
                c. Identify key feature of stabilizing care under EMTALA
                d. Cite key features of appropriate patient transfer under EMTALA
    b. Initial and Ongoing Evaluation
        i. Evaluation of the PA's competence in performing the MSE will be done by the supervising physician(s) as detailed in the *General Policy for Emergency Department Physician Assistant*.

REFERENCES:

1. Certification and Compliance for the Emergency Medical Treatment and Labor Act (EMTALA). Retrieved from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/EMTALA.pdf. 2018 Apr 18.
2. Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases. Retrieved from: http://www.emtala.com/ig.pdf. 2018 Apr 18.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Examination for Emergency Department Physician Assistant – Standardized Protocol	
Scope: Physician Assistants	Manual: Emergency Department, Medical Staff
Source: Chief of Emergency Room Service	Effective Date:

CROSS REFERENCE P&P:

1. *General Policy for Emergency Department Physician Assistant – Standardized Protocol*
2. *Evaluation and Medical Screening of Patients Presenting to the Emergency Department*

Approval	**Date**
Interdisciplinary Practice Committee	4/30/18
Medical Executive Committee	5/7/18
Board of Directors	
Last Board of Directors Review	

Developed: 4/2018 sb
Reviewed:
Revised: 4/2018 dp
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Examination for Emergency Department Physician Assistant – Standardized Protocol	
Scope: Physician Assistants	Manual: Emergency Department, Medical Staff
Source: Chief of Emergency Room Service	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED PHYSICIAN ASSISTANTS

1. ______________________ ______________________ __________
Name Signature Date

2. ______________________ ______________________ __________
Name Signature Date

3. ______________________ ______________________ __________
Name Signature Date

4. ______________________ ______________________ __________
Name Signature Date

LIST OF SUPERVISING PHYSICIANS

1. ______________________ ______________________ __________
Name Signature Date

2. ______________________ ______________________ __________
Name Signature Date

3. ______________________ ______________________ __________
Name Signature Date

4. ______________________ ______________________ __________
Name Signature Date

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8. ______________________ ______________________ __________
Name Signature Date

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

PURPOSE: The purpose of this document is to outline and define safe and appropriate handling of medical waste, and to designate responsibilities of medical waste handling at this facility. It is also to assure compliance with all regulatory agencies and to provide a set of accepted definitions (if required.)

POLICY:
Medical Waste will be handled, stored, treated and disposed of in accordance with regulations as stated in the "Medical Waste Management Act" of the California Health and Safety Code. All chemo waste and all human body parts and human tissue waste undergoes incineration. All other hazardous waste will undergo onsite treatment through the sterilization process. The Medical Waste Management Plan will be reviewed annually by the Director of Maintenance, Infection Preventionist Manager, and Director of Pharmacy. The changes and review will be documented.

TYPES OF MEDICAL WASTE:

- Laboratory
- Blood and other potentially infectious materials (OPIM)
- Chemo Waste
- Contaminated Sharps
- Human Tissue Waste (Pathology)
- Recognizable Human Anatomical Parts
- Pharmaceutical
- Radioactive Waste (handled by Radiology Department)
- Biohazard waste from Small Quantity Generators (none at this time)
- Non-infectious waste

TYPE OF GENERATOR:

- Large Quantity Generator (greater than 600 lbs. per month)

TYPE OF ON-SITE TREATMENT:

- Incinerator
- Steam Sterilization

MEDICAL WASTE MANAGEMENT ACT DEFINITIONS:

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

- **See attached**

CONTAINMENT, TRANSPORT, STORAGE:

- Medical waste is segregated and contained from other hospital waste at its point of origin.
- Sharps are disposed of into sharps containers for disposal.
- All biohazardous waste is red bagged, and when full bags are tied tightly.
- Radioactive waste will be handled in accordance with radioactive waste policy and regulations.
- Medical wastes are incinerated or sterilized as specified in this policy.
- Medical waste will not be stored for longer than 7 days. (At room temperature,)
- All medical waste is transported daily in a covered transport cart to a locked storage dumpster.
- Bags of medical waste will not be placed on floors, in rooms, or corridors; bags are to be placed directly in transport carts
- Items such as broken glass, laboratory slides and sharps or pointed objects, which could puncture a plastic bag, will be placed in sharps containers.
- Bags of normal waste, soiled linens or other materials will not be placed in the transport cart used for transport of Biohazardous waste.
- Environmental Services employees will check the transport cart routinely to ensure it is in good condition, clean, and labeled properly. (Biohazardous Waste or the work Biohazard and the biohazard international symbol.)
- The transport cart must be leak proof, secured tightly with a cover, be labeled on sides and top “Biohazard” and Biohazard symbols.
- Appropriate P.P.E.’s are worn at all times for collecting and transporting.

MEDICAL/BIOHAZARDOUS WASTE AT THIS FACILITY MEANS ANY OF THE FOLLOWING:

- Specimen cultures of any kind.
- All human tissues and all micro and pathology specimens.
- Waste containing discarded materials contaminated with blood or other potentially infectious materials (OPIM) that would release blood or OPIM if compressed.
- Items that are caked with dried blood or OPIM and are capable of releasing these materials.

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

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Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

- Waste compromised of human tissue, which has been fixed in formaldehyde or other fixatives.
- Waste contaminated with trace amounts of chemo agents.
- All contaminated sharps i.e.: needles, scalpel blades, glass pipettes.
- Any liquid or semi liquid blood or OPIM.
- A container, or inner liner removed from a container, which previously contained a Chemotherapeutic agent, is empty if the container or inner liner removed from the container has been emptied by the generator as much as possible, using methods commonly employed to remove waste or material from containers or liners, so that the following conditions are met:

  A. If the material which the container or inner liner held is pourable, no material can be poured or drained from the container or inner liner when held in any orientation, including, but not limited to, when tilted or inverted.
  B. If the material which the container or inner liner held is not pourable, no material or waste remains in the container or inner~~-~~ liner that can feasibly be removed by scraping.

PHARMACEUTICAL WASTE:

Refer to Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs in Policy Manager~~Storage of P-Listed and U-Listed Pharmaceutical Waste for Treatment on Nursing Units:~~

~~The following pharmaceutical waste shall be stored for treatment in Blue-Topped white rigid containers marked with both biohazard symbols and the words "For Incineration".~~

~~a. Opened vials, ampoules, syringes~~
~~b. Opened unit dose drug packages~~
~~c. Opened prescription vials~~
~~d. Opened cream or ointment tubes~~
~~e. Opened bottles of liquids~~
~~f. Opened multi-dose inhaler containers~~

~~Blue-topped white rigid containers for P-Listed and U-Listed Pharmaceutical Waste will be stored centrally on each unit one or more acceptable storage areas. Acceptable storage areas are:~~

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

~~a. Medication Room~~
~~b. Clean Utility Room~~
~~c. Dirty Utility Room~~

~~Storage of P-Listed and U-Listed Pharmaceutical Waste in the Pharmacy:~~

~~All P-Listed and U-Listed Pharmaceutical Waste in the Pharmacy will be stored for treatment in rigid containers labeled with "Chemotherapy" labels.~~

~~a. Unused Chemotherapy is *ALWAYS* returned to the pharmacy for disposal as hazardous waste. Chemotherapy contaminated materials (tubing, gloves, gowns, etc.) are segregated from regular waste into special rigid containers labeled as "Chemotherapy Waste" and incinerated.~~

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PROCEDURE FOR HANDLING AND DISPOSING OF SHARPS WASTE:

~~o~~ Refer to ~~SEE~~Sharps Injury Protection ~~Plan~~ Plan ~~(ATTACHED)~~in Policy Manager

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EDUCATION AND TRAINING:

- All employees who come in contact with blood and OPIM will receive initial and annual training on handling of biohazardous/medical waste as it pertains to their job responsibilities. The education is provided by the Infection Preventionist Manager or Employee Health/Infection Prevention Nurse Specialist, and by online learning management
- Director of Plant Operation is responsible to ascertain safe and appropriate operation of sterilizer and incinerator units by qualified operators.

BIOHAZARDOUS WASTE DISPOSAL FROM SMALL QUANTITY GENERATOR (S.Q.G.) COMMUNITY CENTERS: (None at this time)

To assist medical offices in the disposal of medical (infectious) waste in order to:

- Comply with stringent federal and state regulations.
- Assure safety to hospital and office personnel.
- Prevent access by outside persons or animals.
- Reduce the amount of infectious waste generated.

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

POLICY:

- Infectious waste must be in red plastic bags and must be labeled "biohazardous" in writing or biohazard label.
- Bags must be labeled with office name.
- Bags must not be overfilled and must be tied securely to enable picking up by tied top.
- Double bagging is not necessary except for strength or if outside of bag is soiled.
- Used needles, syringes and sharps must be in biohazard sharps containers and will be sealed with puncture proof lid.
- Infectious waste must be delivered to the hospital maintenance building between the hours of 7:00 AM and 3:30 PM on weekdays only.
- Infectious waste **MUST NOT** be left outside the maintenance building, in the parking lot or the fenced off area near maintenance building.
- Offices must fill in the Medical Waste Treatment Record form located inside the maintenance building, medical waste container.

CONTAMINATED SHARPS FROM THE COMMUNITY:

- Northern Inyo Healthcare District will accept contaminated needles from the community for disposal.
- Refer questions and persons with needles to the Infection Preventionist Manager or Maintenance; ***USED NEEDLES OR NEEDLE CONTAINERS*** must not be accepted by anyone else.
- NIHD will accept contaminated needles from the community for disposal in the Red Kiosk located at the front entrance of the Main Hospital.
- Needle containers may not be supplied to patients or other individuals, for home use.
- All efforts are made to assure appropriate containers are used and will not be accepted otherwise.

CLEANING UP BLOOD SPILLS OR OTHER POTENTIALLY INFECTIOUS MATERIAL (OPIM):

- Blood spills are cleaned up as quickly as possible.
- Blood spills are cleaned up in a manner to prevent exposure to any person.

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

1. Use hospital disinfectant or bleach solution.
2. Wear gloves
3. Use disposable rag, paper towel or mop.
4. To avoid aero-soling, do not spray into spill.
5. Dampen rag with cleaning solution, wipe up.
6. Re-clean area with clean rag and solution.
7. As an alternative, sprinkle spill with jelling powder, seep up with dustpan and broom.
8. Red bag granules.
9. Clean dustpan and broom by swishing in cleaning solution on cleaning cart or with rag.
10. Wipe up as in steps 5 and 6.
11. Blood spill kits are ~~located in all clinical areas.~~available

BIOHAZARDOUS WASTE CARTS AND CLEANING:

- Large rigid, wheeled carts are used to transport biohazardous waste from the hospital units to locked storage dumpster.
- Environmental Services will check that carts are clean and in good condition at all times.
- Carts are lined with red bags; this bag is disposed of with biohazardous waste.
- Carts are cleaned on a regular basis.

STEAM STERILIZER/COMPACTOR *MAINTENANCE:*

The steam sterilizer and compactor are maintained and inspected to ensure safe and proper operation and that infectious materials are fully sterilized in compliance with State and Federal regulations.

PROCEDURE/STERILIZER:

Daily:
Walk around the unit, check for damaged hoses and leaks. Remove any litter that may have accumulated around the sterilizer.

Open the sterilizer door and check the seal for damage and debris.

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Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
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Clean drain screens (parts #41 and #45 on drawing #100A06.) Remove screens by lifting from the drain hole and check for the presence of debris and sediment that might restrict the flow of condensate (water.) Use a wire brush to loosen the debris, rinse thoroughly, and replace in the drain hole.

Clean "Y" strainers (Parts #6 and #39) with a crescent wrench (adjustable open end wrench) remove the large nut from the strainer. Carefully remove the internal strainer screen, clean and rinse the screen and replace, this should be done weekly.

Check the sterilizer carts for plastic residue or other debris and remove. Use a scraper if necessary.

Check the sterilizer door for alignment by slowly closing the door. If you hear scraping noises that might indicate misalignment, repair it immediately.

Weekly:

Clean wire strainers.

Recorder chart: Open the cover of the recorder with your fingers, unscrew the round knob in the center of chart. Replace with new chart. Release the pen holder; swing the arm out of the way. Gently pull the pen holder about ¼" away from the paper chart. Then remove the chart. Replace with a new chart. Release the pen holder, swing the arm back in place and gently tighten the center knob. (**Do not over tighten the knob.)**

Check the Roto-Wedge door.

a. Remove any debris from the wedges and gasket.

b. Lubricate the face of the wedges with high temperature grease such as Shell Oil Company. "DARINA-EP".

c. Lubricate hinges and bearings, grease fittings are provided on the hinge and bearing housings. Use an alemite gun with high temperature grease such as shell "DARINA-EP".

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NORTHERN INYO HEALTHCARE DISTRICT
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d. Lubricate the gasket. Wipe off the gasket and the door with a clean rag to remove any debris. Spray a thin layer of high temperature Teflon based lubricant such as "Tri-Flow" on the gasket.

Sterilizer carts. Grease fittings are provided on each caster. Turn the carts on end. Inject high temperature grease such as "DARINA-EP" in each caster.

Check hydraulic hose fittings for damage and tighten the fittings if required.

The exterior of the sterilizer is thoroughly cleaned, primed and painted with a premium coating; however, rust may develop in certain areas due to the high moisture environment and frequent washing. Minor rust may develop due to scratches or other breaks in the coating. When rust develops, thoroughly dry the area, wire brush to remove any loose coating, and apply a recommended primer. Primed areas can then be touched up with finish coating.

Check hydraulic oil level and top off with approved hydraulic oil if necessary.

Monthly:

Perform biological indicator test monthly to confirm the attainment of adequate sterilization conditions.

Yearly:

Even though the hydraulic system is used on a limited basis (only when opening and closing the door), it is recommended that the hydraulic fluid be drained and replaced annually.

Thermometers are checked annually for calibration and records of the calibration checks are maintained as part of the maintenance files and records for a period of three years.

PROCEDURE/COMPACTOR:

Prior to performing any maintenance on the compactor or power unit, shut off the power at the disconnect switch and lock this switch in the "off" position. See power lockout procedure on

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

page 3. Do not service the machine if it is possible for someone to start the machine while it is being serviced.

The self-contained compactor has grease zerts on the four cylinder pins, the four container wheels, and the container door hinges. These zerts must be greased monthly or more often depending on usage. Grease the cylinder pins until grease can be seen between the pin and pin plate.

Take the rear cover off the compactor, check for trash build up in the cylinder area, and clean when necessary.

The power units use a permanent type oil filter which may be reused after each cleaning. To keep down time at a minimum while cleaning the dirty filter, replace it with a spare clean filter. The dirty filter may then be cleaned as follows:

a. Soak the filter in kerosene or other solvent to loosen the contaminant.

b. Lightly scrub the filter with a soft bristle paint brush. **DO NOT USE A**
   a. **WIRE BRUSH.**

c. Remove embedded contaminants with clean, dry shop air. Direct the flow of air against the side of the filter with a perforated support.

d. Again, wash the filter in a solvent and blow with shop air, then inspect for damage. Holes in the filter cloth will leak dirt into the pump and valve which may cause malfunctions in the hydraulic system.

See chart below for recommended filter change frequency.

USAGE	FILTER CHANGE OR CLEAN FREQUENCY
Heavy: 6 hrs. per day	Initial change after 2 weeks, thereafter every 3 months
Medium: 2-6 hrs per day	Initial change after 3 weeks, thereafter every 6 months
Light: up to 2 hrs. per day	Initial change after 4 weeks, thereafter every 12 months

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

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INITIAL MAINTENANCE CHECK

The first maintenance check should take place with the first filter change and include the following:

a. Check and tighten all electrical and hydraulic connections on the power unit, control head, and cylinder.

b. Check and tighten all mechanical fasteners, nuts, bolts, set screws, etc.

c. Drain some hydraulic fluid from the bottom of the reservoir by removing the ¾" plug from the half coupling under the oil level gauge. Inspect the fluid for the presence of water. Drain all water.

d. Check the wear guide shoes, or Nylatron guide blocks, located on the rear of the ram, for looseness and unreasonable wear. Call a factory authorized representative if wear seems excessive or uneven.

Under normal conditions the fluid can be used for an indefinite time. If you suspect that the fluid has been contaminated or has otherwise lost its usefulness, drain off some of the fluid, take it to an oil distributor and have it analyzed.

The bottom of the reservoir should be inspected every 12 to 18 months for sludge deposits. If there is a detectable layer of sludge, the reservoir should be drained, flushed with kerosene or another suitable solvent, and then refilled with clean hydraulic fluid.

Recommended oil may be used for all but extremely cold temperatures. An immersion oil heater is recommended for an area where temperatures are expected to frequently reach 0 degrees F or below.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

INCINERATOR OPERATION:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

The following procedure shall be followed by all appropriate personnel to ensure the safe operation of the TR-10 Incinerator. This unit is operated approximately once per week.

PROCEDURE

1. Put on Personal Protective Clothing, (i.e. gloves, eye protection, cover gown.) Any questions regarding P.P.C. refer to your Infection Control Manual.

2. Preheat the primary and secondary burners, by turning the burner on, for approximately twenty-five minutes, prior to actual burning.

3. After the primary and secondary burners have been allowed to burn for twenty-five minutes, shut both burners off, completely.

4. Load approximately thirty pounds of medical waste, into the chamber. Do not cover the burner ports.
5. Turn on both burners. After two minutes, turn off primary burner. Let secondary burner run for twenty minutes, to complete incineration.

6. After the waste has been incinerated for twenty minutes, repeat steps four through six for additional incineration.

7. Log all incinerator activities on the appropriate Incinerator Log Sheets.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

The following procedure shall be followed by all appropriate personnel, to ensure the safe operation of the steam sterilizer and compactor. This unit is operated approximately three times per week.

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

PROCEDURE/STERILIZER:

1. Put on Personal Protective Clothing, (i.e. gloves, eye protection, cover gown.) Any questions regarding P.P.C. refer to your Infection Control Manual.

2. Safety door latch: Place handle in the open position.

3. Push **door open** button on control panel.

4. Lower loading ramp and remove sterilizer cart, place liner into sterilizer cart, and cut a few holes in the liner to allow moisture to escape.

5. Push cart to Infectious Waste Bin and begin placing Red Bags and Sharp containers into the cart, (this should be about 15-20 bags) do not load bags too high in the cart as the load should be able to be placed into the sterilizer without any bags touching the inside of the vessel, using autoclave tape, tape the bag shut as much as possible. (does not require a tight seal.)

6. Close sterilizer door, push **door close** button on the control panel, place safety T handle into the locked position.

7. Visually look around the sterilizer, steam lines, water lines, and drains, making sure these areas are clear.

8. Turn water valve on.

9. Push **cycle start** button.

10. Check to assure sterilizer read out time is set for 45 minutes.

11. Cycle light on control panel will go off when load is done.

12. It is recommended to let vessel temperature drop to approximately 200 degrees before opening the door.

13. Be sure to put on welding gloves before opening door and unloading the cart, as the load will be **hot**.

14. Before placing sterilized waste into compactor, be sure the chart on the control panel indicated 280 degrees temperature for 45 minutes was achieved and the autoclave tape has

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Title: Medical Waste Management Plan	
Scope: NIHD	Manual: Maintenance & CPM: Infection Control
Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

turned brown. If the chart does not read 280 or the tape has not change color, re-run the load. If the second load fails, mark the load as not sterile, remedy the problem with the equipment and re-run the load.

15. Put cart on Compactor ram and dump the sterilized waste into the compactor (see procedure for compactor.)

16. Place cart back into sterilizer; close the door, push **door closed** button until door locks, turn water valve off.

PROCEDURE/COMPACTOR:

1. Assure that compactor ram is in the retracted position.

2. Place dumping container in dumper and secure.

3. Close any gates or barriers surrounding dumper.

4. Pull red "**Emergency Stop**" button to outer most position.

5. Set Compactor / Dumper switch to Dumper.

6. **Turn and hold** keyed "Start" switch to start position. (deadman operation) The dumper **will not** function unless the keyed switch is held in the start position.

7. Turn "**Up/Down**" switch to "**UP**" until dumper stops at the end of the dumper stroke.

8. When all refuse has emptied from container, turn and hold "**Up/Down**" switch to the "**Down**" position until dumper comes to rest in starting position and release key.

9. After the above process has been completed, set the "**Compactor/dumper**" switch to "**Compactor**".

10. Assure that the red "**Emergency Stop**" button is pulled out to the outer most position.

11. Turn the "**Keyed Start**" switch to "**Start**" and release.

The compactor will cycle the pre-determined number of cycles and shut off automatically.

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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

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Scope: NIHD	Manual: Maintenance & CPM: Infection Control
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The process is now complete and ready to be repeated.

Caution

Make sure all personnel are clear of dumper before operation.

Make sure that all safety gates are closed and all inter-lock switches are functioning properly.

Do not switch to dumper operation until compactor has completed cycling and power unit shuts down.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

CLOSURE PLAN:

Should NIHD ever experience a termination of this treatment facility, we would have to hire an out of the area vendor to haul away our Medical Waste. The treatment facility would then be disassembled and disposed of properly.

TABLE 1: WASTE ITEMS AND APPROPRIATE DISPOSAL CONTAINERS

DESIGNATED CONTAINER				
WASTE ITEM	**Sharps Box**	**Red Bag**	**Regular Bag**	**Other Designated Containers**
Needles/syringes	**X**			
Lancets	**X**			
Any other sharps	**X**			
Lab and microbiology used specimen tubes or media plates	**X**			

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NORTHERN INYO HEALTHCARE DISTRICT
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Broken glass	**X**			
Gloves, gowns, masks (dripping with blood)		**X**		
Any Dressings or Chucks (saturated with blood or other drainage)		**X**		
Foley catheters/bags with blood		**X**		
Any drainage receptacle		**X**		
Any drainage tubes		**X**		
Blood bags		**X**		
Peripads or tampax (dripping with blood)		**X**		
IV lines and bags (with blood)		**X**		
IV catheters			**X**	
IV lines and bags (no blood)			**X**	
Bedpans, urinals, emesis basins			**X**	
Ventilator tubing			**X**	
Foley catheters and bags			**X**	
Any dressings or chucks (minimal blood)			**X**	
Peripads or tampax (not saturated with blood)			**X**	
Diapers			**X**	
ET tubes and suction catheters/Ng tubes			**X**	
Gloves, gowns, aprons, masks (no blood or slightly stained with blood)			**X**	
Tissues and paper towels			**X**	
Guiac and Gastro-occult cards			**X**	
Chemotherapy items Trace				**Yellow rigid container:**

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NORTHERN INYO HEALTHCARE DISTRICT
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Scope: NIHD	Manual: Maintenance & CPM: Infection Control
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				chemo bucket
Pharmaceutical Waste: Hazardous Drugs and Bulk Chemotherapy				**Black Bin**
Pharmaceutical Waste: General				**Blue and White Container**
Pharmaceutical Waste: Controlled Substance				**Opaque Green Bin**

Note: The general pharmaceutical waste, trace chemotherapy waste, and controlled substance will be picked up by Medi-Waste vendor to be incinerated. These items will be stored in EVS storage room until packaged and mailed out. When packaged the waste containers will be sent to Purchasing to be officially mailed out.

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). (2018). Waste Management. Retrieved from http://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/waste-management
2. California Department of Public Health (2017). Medical Waste Management Plan Checklist. Retrieved from https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8661.pdf
3. California Department of Public Health (2017). Medical Waste Management Act: California Health and Safety Code Sections 117600-118360. Retrieved from https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/MedicalWasteManagementAct.pdf
4. Occupational Safety & Health Administration (accessed March 17, 2018). Standard Number 1910.1030 Feminine Products. Retrieved from https://www.osha.gov/laws-regs/standardinterpretations/1992-10-08

CROSS REFERENCE P&P:

1. Blood Borne Pathogen Exposure Control Plan
2. Sharps Injury Protection Plan
3. Lippincott Procedures Personal Protective equipment (PPE), putting on
4. Lippincott Procedures Personal Protective equipment (PPE), removal
5. Hazardous Spill & Exposure EC. 02.02.01 EP 3-4
6. Opioids Waste Policy

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NORTHERN INYO HEALTHCARE DISTRICT
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Title: Medical Waste Management Plan	
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Source: Director of Maintenance/Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 8/2005

7. Reporting Hazardous Material & Waste Incident EC. 04.01.01 EP8
8. Hazardous Material & Waste Inventory EC.02.02.01EP1
9. Safe Handling and Disposal of Occupationally hazardous Drugs and Environmentally Hazardous Drugs
10. Management of Hazardous Chemical EC.02.02.01EP 5
11. Labeling Hazardous Material & Waste EC02.02.02EP 12
12. Hazardous Material & Waste Management Plan
13. Formaldehyde EC.02.02.01 EP9
14. Disposal of Radioactive Waste

Approval	**Date**
CCOC	4/23/18
Infection Control Committee	5/1/18
Medical Executive Committee	5/7/18
Board of Directors	
Last Board of Directors Review	10/2012

Developed: August, 2005
Reviewed: October, 2012
Revised: November, 2017, 3/2018 CH/DW/NV/RC
Supersedes: Disposal of Bottled Body Fluids, Handling of Infectious/Non Infectious Waste, Cleaning Up Blood Spills, Infectious/Bio-Hazardous Substance Communication Program

Index Listings: Waste, infectious waste, pharmaceutical waste

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medication/Solution Transfer to the Sterile Field*	
Scope: ED, OR, DI, RHC	Manual: CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 5/24/16

PURPOSE:
To provide guidance to personnel for transferring or receiving medications to the sterile field. The expected outcomes are that the patient will be free from signs and symptoms of infection and that the correct patient will receive the correct medication(s) in the correct dose, at the correct time, via the correct route, for the correct indication, and with the correct documentation throughout the procedure.

POLICY:
Licensed personnel designated to transfer and handle medications on a sterile field will utilize this policy/ procedure, titles and roles may vary depending on unit / department.

- Personnel will only transfer medications to the sterile field or prepare medications on the sterile field if it is within their job descriptions and their scopes of practice for licensure.
  - In surgery the RN circulator will be the primary person to transfer medications to the sterile field.
  - The person to prepare the medication on the sterile field will be employed by the health care organization unless he or she is a licensed independent practitioner who will be preparing and administering the medication.
  - Licensed independent practitioners who are not employed by the health care organization will follow the procedures for verifying the medication before it is administered to the patient.
- When medications are removed from their original containers, personnel will follow the verification process (see the policy and procedure "Administering of Drugs and Biologicals") before medications are administered.
- Personnel will use sterile technique when transferring medications to a secondary container on the sterile field.
- For medications administered on the sterile field, personnel will hold all primary and secondary medication containers until the end of the procedure.
- All medications, sharps, and syringes are disposed of immediately at the end of the surgery or procedure.
- Part of any hand-off during a procedure will include a verbal review of any medication / solution both on and off the sterile field between staff entering and exiting the area where a procedure is being performed.

PROCEDURE INTERVENTIONS:
- When medications are removed from their original containers and transferred to the sterile field, personnel will implement the following safe practices for verification of the medication before it is administered.
- **The RN circulator or other licensed person will:**
  - Check the expiration date and visually inspect the medication for compromise before transferring the medication to the sterile field.
  - Use safety devices (eg, blunt needles) when preparing (eg, reconstituting) the medication.
  - Confirm dose limits previously established before transferring the medication to the sterile field.
  - Use a sterile transfer device to transfer medications to a secondary container on the sterile field.
  - Not remove rubber stoppers from medication containers.
  - Transfer one medication at a time.
  - Verify the medication name, strength, dosage, diluent / diluent volume and expiration date concurrently with the person receiving the medication on the sterile field.
  - Confirm the (sterile) label applied to the secondary medication container with the scrub person.

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Title: Medication/Solution Transfer to the Sterile Field*	
Scope: ED, OR, DI, RHC	Manual: CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 5/24/16

- **The scrub tech or person that has donned sterile attire will:**
  - Verify the medication name, strength, dosage, and expiration date concurrently with the RN circulator or licensed person when receiving the medication on the sterile field.
  - Label the secondary medication container with the medication name, strength, concentration, and other pertinent information (eg, expiration date for time-sensitive medications).
  - Present the label to the RN circulator or licensed person for confirmation.
  - Give a verbal confirmation of the medication when handing it to the licensed independent practitioner for subsequent administration.
  - Use safety devices (eg, self-capping needles, hemostats to remove needles from syringe).
  - Use sharp safety practices when handing medications to or receiving medications from the licensed independent practitioner who is administering the medication.
  - Discard any solution that is found on the sterile field without an identification label.
- Perioperative or procedure team members will monitor for processes that inhibit safe medication use, including safe injection practices.
- Perioperative or procedure team members will monitor compliance with safe handling of chemicals, cytotoxic agents, and hazardous waste in the workplace.
- When observing for potential risks where medications are used, perioperative or procedure team members will address environmental conditions, including:
  - space,
  - illumination,
  - noise, and
  - interruptions.
- Perioperative or procedure team members will actively participate in error reporting according to hospital policy regardless of where the error originates within the medication-use process and whether patient harm results from the error.

DOCUMENTATION

- The RN circulator or licensed person will document who administered medications and all activities related to medication administration as soon as possible after the time the medication was administered.
- The RN circulator will document all medications administered intraoperatively, with the exception of those medications administered by anesthesia professionals. In other settings, the licensed independent practitioner will document /dictate medications used in the procedural report.
  - Medications administered (dose, strength, route, time) will be documented on the intraoperative record and orders or unit specific documentation form.
- Perioperative or procedure team members who administer medications will document patient responses to administered medications as soon as possible after the time the medication was administered.
- In the presence of an ineffective response or adverse events, perioperative or procedure team members who administer medications will document actions initiated or interventions implemented.
- Perioperative or procedure team members will document and report medication errors as close as possible to the time the error occurred by following hospital policy for reporting of medication errors.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medication/Solution Transfer to the Sterile Field*	
Scope: ED, OR, DI, RHC	Manual: CPM - Operative, Invasive Procedures, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 5/24/16

COMPETENCY

All licensed personnel who administer medications will receive education and complete competency validation activities, including those on

- medication safety,
- medication administration,
- the medication-use process, and
- risk reduction strategies and the use of sharps safety devices for preventing sharps injuries.

REFERENCES

1. Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2010.
2. Recommended practices for medication safety. In: *Perioperative Standards and Recommended Practices.* Denver, CO: AORN, Inc; 2013:271-272.

CROSS REFERENCE P&P:

1. Surgery Medication and Solution Policy

Approval	**Date**
CCOC	1/29/18
STTA	4/25/18
MEC	5/7/18
Board of Directors	5/18/16
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Reviewed:
Revised: 12/26/17aw
Supersedes:
Index Listings: Medications on a Sterile Field, Transferring Medications on a Sterile Field

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Care Guidelines in PACU	
Scope: PACU	Manual: PACU Section III
Source: DON Perioperative Services	Effective Date: 4/98

PURPOSE:
These guidelines outline the nursing care that will be given to the PACU patient.

POLICY:
The following care guidelines will be followed for inpatients and outpatients in the PACU. The PACU nurse will be an RN who has completed BLS, ACLS, and PALS in the last two years and is fully oriented to the PACU.

GUIDELINE 1: The PACU nurse will assess and maintain ventilation of the patient.
Criteria

1. Maintain the airway.
   1.1. Determine patency. If upper airway obstruction is present

      1.1.1. Reposition head.
      1.1.2. Apply jaw thrust and/or chin lift as needed.
      1.1.3. Insert oral airway or nasal airway as needed.
      1.1.4. Suction as needed: oral, nasal or endotracheal tube.
      1.1.5. Notify anesthesia provider of airway obstruction.

   1.2. Position patient on side if not reactive.
   1.3. Elevate head of bed 30 degrees if not contraindicated.
   1.4. Encourage patient to take deep breaths and cough every 15 minutes.

2. Monitor respirations.
   2.1. Obtain respiratory rate on admission to the PACU and continue to document rate every 5 minutes, three times, and then, if stable, every 15 minutes.
   2.2. Document chest expansion; observe for use of auxillary muscles.
   2.3. Auscultate bilateral breath sounds and document; note depth of respirations.
   2.4. Notify anesthesiologist if respiratory rate drops below 10/min and encourage patient to breathe deeply; have reversal agents available.

3. Observe the skin.
   3.1. Note color of lips, nailbeds, and extremities.
   3.2. Note temperature of skin.

4. Maintain the oxygen delivery system.
   4.1. Apply oxygen mask at 6-10 liters/minutes or nasal prongs at 2-6 L/minutes or "blow by" nebulized oxygen as requested by the anesthesiologist.

5. Monitor arterial oxygen saturation.
   5.1. Apply pulse oximeter until PACU discharge criteria has been met.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Care Guidelines in PACU	
Scope: PACU	Manual: PACU Section III
Source: DON Perioperative Services	Effective Date: 4/98

GUIDELINE 2: The PACU nurse will assess and maintain hemostasis and circulation.
Criteria

1. Obtain heart rate on admission to the PACU, and continue to document rate every 5 minutes threes times, and then, if stable, every 15 minutes.

2. Place every patient on a cardiac monitor. Lead II will be monitored unless requested otherwise by the anesthesiologist.

3. Document heart rhythm on arrival to the PACU. Document any change in rhythm while in the PACU; notify anesthesia provider of any change while in the PACU, or if the initial rhythm is different from the patient's preoperative status.

    3.1. ACLS Guidelines (established by the American Heart Association) will be followed when treating a dysrhythmia in the PACU. A current ACLS and PALS manual will be kept in the PACU.
    3.2. PALS protocols may need to be initiated if the patient is age 13 or under.
    3.3. The patient’s physician will be notified whenever the ACLS protocols are initiated.

4. Obtain blood pressure (BP) on admission to the PACU (via cuff or A-line) and continue to document BP every 5 minutes three times, and then, if stable, every 15 minutes.

5. If the patient is hypertensive or hypotensive on admission to the PACU (determined by comparison with preoperative and/or intraoperative BP), continue to document BP every 5 minutes until stable and acceptable, and then every 15 minutes.

6. If the patient is receiving intravenous (IV) vasoactive drugs, document the BP every 5 minutes until stable and acceptable by the anesthesiologist.

7. If central venous pressure is being monitored, document reading every 15 minutes.

8. If pulmonary artery pressure is being monitored, document reading every 15 minutes.

9. Document urine output every hour (if Foley catheter in place).

10. Document urine color on arrival to the PACU; if any change occurs; and on discharge.

11. Check peripheral pulses when indicated (e.g., extremity surgery, vascular surgery, spinal cord surgery), and document on arrival to PACU, every hour, if any change occurs, and on discharge.

12. Report the presence of the following to the anesthesiologist or surgeon:

    12.1. Decreased urine output - less than 0.5cc/kg per hour.
    12.2. Cyanosis.
    12.3. Excessive perspiration.

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12.4. Any sign of hemorrhage.

13. Maintain IV fluids at 100 ml per hour or at prescribed rate.

14. Observe dressings for amount of bleeding or drainage every 30 minutes if dry or every 15 minutes if drainage is present. Reinforce dressing or change as needed. Carefully estimate and document amount *of* bleeding.

15. Make sure all drains and/or tubes are patent. Document amount and characteristics of drainage on admission to and discharge from the PACU. Empty hemovacs, J-P drains, etc. as necessary. Connect hemovacs and nasogastric tubes as ordered.

16. If patient becomes hypotensive and is symptomatic, position patient flat, infuse IV fluid rapidly (unless contraindicated), administer oxygen, notify the anesthesia provider and surgeon, and continue to monitor BP every 3 to 5 minutes. Have emergency drugs available.

17. If patient becomes bradycardic (heart rate 50 and is symptomatic, notify the anesthesia provider and surgeon, administer oxygen (40% face mask or 3 L nasal prongs), have medications (atropine and ephedrine) available, and continue to monitor vital signs every 3 to 5 minutes.

18. Vital signs on an outpatient are taken as directed in 2.1 and 2.4 until patient is ready for discharge. Vital signs are taken at least once after the patient has ambulated prior to his/her discharge home.

GUIDELINE 3: The PACU nurse will assess level of consciousness and promote reactivity.
Criteria

1. Frequently orient the patient to surroundings and to the fact that surgery is over.

2. Assess level of consciousness; document every 15 minutes until oriented to preoperative level.
    - 2.1. Assess verbal response by asking the patient "Where are you," What is your name," What (day) (month) (year) is it?"
    - 2.2. Assess eye opening by noting if the patient opens eyes spontaneously or only when asked.
    - 2.3. Assess motor response by asking the patient "squeeze my hand" (do this bilaterally), and "move your feet."

3. Assess and document level of spinal or epidural anesthesia.
    - 3.1. Level will be assessed and documented on arrival to the PACU and reported to the anesthesia provider.
    - 3.2. Continue to assess level every 30 minutes. Document *if* there is a change; if no change, document level every 1 hour.
    - 3.3. Assessment will include bilateral sensory and motor level.

4. Assess and document pupillary response every 30 minutes when indicated (e.g., carotid endarterectomy).

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5. Reduce anxiety by giving reassurance and support.

6. Be familiar with anesthetic agents used and special considerations in doing this (e.g. Ketamine).

GUIDELINE 4: The PACU nurse will assess and promote fluid and electrolyte balance.
Criteria

1. Document bottle number, solution, and additives of parenteral infusions on arrival to the PACU.

2. Note intravenous system patency on arrival to the PACU and every 15 minutes.

3. Maintain the IV rate ordered by the anesthesia provider. If not specified, maintain at the rate ordered by the surgeon in the postoperative orders or at 100 cc per hour.

    3.1. Use a pump to deliver IV additives other than pitocin, or vitamins unless otherwise specified by physician.
    3.2. Apply pump tubing to IV's on inpatients.

4. Apply stabilizing device for IVs as needed (armboards, restraints).

5. Keep the inpatient NPO unless otherwise ordered. Advance diet as tolerated for the outpatient as ordered, start with ice chips.

6. Report results of any abnormal values of emergency laboratory work to the anesthesiologist. Document the laboratory results and that the appropriate person was notified. Document any action taken as the result of the laboratory findings.

7. Continuously observe for signs of hemorrhage.

8. Observe for bladder distention and discomfort, if Foley catheter not present. If Foley catheter present, proceed as directed in Standard 2, 9.0, 10.0 and 12.1.

9. Document amount and character of any emesis. Notify the anesthesia provider of persistent nausea and/or vomiting. Medicate patient as directed by the anesthesia provider. Document medication administration and effect.

10. Record intake and output on PACU record and complete 24 hour Intake and output sheet on Inpatients.

GUIDELINE 5: The PACU nurse will ensure the safety of the postoperative patient.
Criteria

1. Have siderails up constantly when not at bedside.

2. Use bumper pads for protection of a restless or combative patient.

draft

3. Notify the anesthesia provider if restraints are necessary.

4. Use all electrical equipment in the proper manner.

5. Properly label any IV additives and document medications administered.

6. Transport patients with safety equipment as needed (Vaseline gauze and chest tube clamp for patients with closed chest drainage, tracheotomy kit for patient's s/p neck surgery).

7. With same-day surgery patients, lock all four wheel brakes on the stretcher before helping the patient to get up. Have a step stool available for the patient to use.

8. Make sure all equipment is in proper working order. If not, take the equipment out of service and notify the appropriate person for repair.
   - 8.1. The oxygen supply, suction supply and defibrillator will be checked daily.
   - 8.2. Expiration dates on drugs and IV solutions will be checked monthly by the Pharmacy.
   - 8.3. All overbed shelves will be stocked daily with oxygen masks, oxygen cannulas, emesis basins, tissues, lidocaine jelly and bit blocks. Presence of IV poles, oxygen tank, ventilator, supply cart, IBP monitors, oximeters, gurneys will be noted as well.
   - 8.4. Supplies will be checked/reordered. Laryngoscope handle/blades checked weekly.

GUIDELINE 6: The PACU nurse will provide for assistance with emotional and spiritual needs.
Criteria

1. Provide for the patient's right to privacy, including use of curtains and enforcement of traffic control policy.

2. Provide emotional support with positive and encouraging verbal and nonverbal communication.

3. Maintain a calm, confident manner when caring for the patient.

4. Explain all procedures before performing them.

5. Respect the patient's religious beliefs and preferences.

GUIDELINE 7: The PACU nurse will promote the comfort of the postoperative patient.
Criteria

1. Turn and reposition patient as indicated. Document patient's position on arrival as well as any position changes in the PACU.

2. Check for restrictive dressings.

3. Provide for hygiene as needed.

4. Keep patient well covered, using warmed blankets unless contraindicated.

draft

5. Document patient's temperature on arrival to the. PACU.
    5.1. If temperature < 96 degrees F, apply patient warmer per anesthesia provider's order. Document temperature every 15 minutes until temperature is 96 degrees F and then again prior to discharge. Discontinue patient warmer when patient reaches 96 degrees F and patient is comfortable.
    5.2. If temperature is > 96 degrees F document again on discharge. Apply warmed blankets as patient requests.
    5.3. Temperatures will be taken tympanically on all patients including children unless otherwise ordered.

6. Assess the patient's level of pain using a scale of 0 - 10 if indicated.

7. Administer analgesic as ordered by the anesthesia provider or surgeon.
    7.1. Analgesic will be administered IV or as ordered by anesthesiologist or surgeon.
    7.2. Analgesic will be titrated to the desired level of comfort while monitoring side effects, (heart rate, BP, airway obstruction, respiratory rate, nausea, vomiting). Vital signs will be documented every 10 minutes while administering IV analgesics until 20 minutes after the drug is given.
    7.3. Administration of analgesia will be documented including reason for administration and effect of the medication.
    7.4. If the patient is to use patient-controlled analgesia postoperatively, the PACU nurse will set up the pump, prepare the IV site to accept the infusion, and explain the use of the pump to the patient (This explanation will be reinforced by the unit nurse, who will initiate use of the pump.)
    7.5. Outpatient prescriptions are called to desired pharmacy.

GUIDELINE 8: The PACU nurse will promote continuity of care for the postoperative patient.
Criteria

1. Obtain a complete intraoperative report from the anesthesia provider including, but not limited to the following:

    1.1. Identify the patient.
    1.2. Review of the patient's general health and any problems such as chronic disease or addiction.
    1.3. Actual surgical procedure.
    1.4. Anesthetic agents used and the patient's tolerance.
    1.5. Any surgical or anesthetic complications.
    1.6. Replacement of fluids (type and amount).
    1.7. Urinary output.
    1.8. Presence of drains, etc.

2. Initiate physician's orders promptly and document them. Notify Pharmacy of any medication needed in PACU and time of antibiotics administered In O.R.

3. Give the receiving nurse a call re: equipment needed and patient's time of arrival so preparations for care of the patient may be made (Inpatients) or notify responsible adult of patient's potential discharge time and needed equipment or medication (Outpatients).

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4. Document the patient's status at time of discharge, including:

   4.1. Level of consciousness.
   4.2. Level of comfort.
   4.3. Conditions of dressings(s).
   4.4. Patency of tubes, drains, catheters, IV lines.
   4.5. Intake and output.
   4.6. Skin color.
   4.7. Nerve and circulation status including radial and ulnar nerve check.

5. Transport the patient to room and assist in transfer into bed, when patient meets discharge criteria (Inpatients) or discharge patient to car with responsible adult (Outpatients).
   5.1. Document to whom report was given.
   5.2. Document initial vital signs taken by the nursing person receiving the patient.
   5.3. If the PACU nurse Is unavailable to transport the patient due to staffing needs in the PACU, arrange for a unit nurse to transport the patient. Instruct the unit nurse to notify the PACU of the patient's initial vital signs on arrival to the unit, and arrange for their documentation.

6. Give the receiving registered nurse a complete report so that continuity of patient care is assured.
   6.1. Identify the patient.
   6.2. Surgical procedure.
   6.3. Type of anesthesia and any particulars of which the nurse should be aware in caring for the patient (e.g., indwelling epidural catheter and naloxone).
   6.4. Any surgical or anesthetic complication.
   6.5. Replacement of fluids and/or blood in the OR and the PACU.
   6.6. Urinary output In the OR and the PACU.
   6.7. Status of dressing(s) and amount and type of drainage.
   6.8. Output from drainage tubes and devices.
   6.9. Respiratory status.
   6.10. Vital signs
   6.11. Neurological status.
   6.12. Review of postoperative orders.
   6.13. Review of any medications administered in the PACU including their indications and effects.
   6.14. Level of comfort.

7. Written discharge instructions will be sent home with outpatients.
   7.1. The instructions will include a way to access the physician and the hospital for questions and problems.
   7.2. Document the person(s) receiving the discharge instructions, in the PACU record.
   7.3. Document additional educational material sent home with the patient on the discharge instruction sheet.
   7.4. If discharge medication prescription has been phoned to a pharmacy, note the name of the pharmacy on the discharge instruction sheet.

8. Discharge outpatients home per physician order after they have met the discharge criteria.
   8.1. Document person(s) receiving the discharge instruction review.

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Care Guidelines in PACU	
Scope: PACU	Manual: PACU Section III
Source: DON Perioperative Services	Effective Date: 4/98

8.2. Document how and with whom the outpatient was discharged.
8.3. Document items with which the outpatient was discharged (Rx, instructions, personal belongings, equipment, etc.).

REFERENCES:

1. TJC PC 03.01.07, Title 22 CA Code Regulations 76235 d-f
2. ASPAN 2012-2014 Perianesthesia Nursing: Standards, Practice Recommendations and Interpretive Statements, Standard IV, Practice Recommendations 2-6

CROSS REFERENCE P&P:

1. Standards of Care PACU, PACU Discharge Criteria

Approval	Date
CCOC	1/29/18
STTA	4/24/18
MEC	
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Developed: 3/98
Reviewed:
Revised: 3/06, 5/10 aw, 5/11aw, 9/12 aw, 12/17aw
Supersedes:
Index Listings: Guideline, Nursing, PACU; Nursing Care Guidelines, PACU; Care, Nursing Guidelines, PACU; PACU Nursing Guidelines

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Preoperative Preparation and Teaching	
Scope: PACU, Surgery	Manual: CPM - Communication (COM)
Source: DON Perioperative Services	Effective Date: 12/2013

PURPOSE:

To expedite admission of surgery patients and to insure continuity of care thereby promoting patient safety and alleviating patient anxiety.

Preoperative teaching is to ensure the patient's understanding of and general timing of the operative day, as well as the procedures and equipment that will be used in the Operating Room, Recovery Room and the other nursing units. This will help the patient to be as relaxed as possible and have a better pre and postoperative experience.

POLICY:

1. All patients will be admitted to the Operating Room following these guidelines.
   Do Not Resuscitate (DNR) will be suspended, unless continued by the treating physician upon review prior to going to surgery.

2. Patients selected for outpatient surgery should meet the following criteria:
   - The operation should be a procedure that is not usually accompanied by significant blood loss or physiological derangement post operatively.
   - The incidence of post operative complications should be low.
   - The patient should be in good health or have mild systemic disease.
   - It should be understood that pre operative preparation and post operative care can be safely accomplished in an outpatient environment.
   - The surgeon selects the patient, provides written instructions, and schedules the procedures. The instructions describe the pre operative work-up, admission, and recovery periods.
   - Patients with BMI greater than 40 or history of O.S.A. (Obstructive Sleep Apnea) may not be a candidate for outpatient surgery requiring general anesthesia/procedural sedation.
   - Dental and podiatry patients shall be admitted under the service of a medical staff physician with a medical history and physical examination pertinent to the patient's general heath.
   - The podiatric history should justify hospital admission and include a detailed description of the examination of the foot and a preoperative diagnosis.

3. Patient teaching for elective surgery will include preoperative preparation, postoperative care, and information re: prevention of hospital acquired infection. Patients will receive teaching and handouts appropriate to their scheduled surgery (Surgical Site Infection Prevention, Central Line, Catheter Associated Urinary Tract Infection, Ventilator Associated, and information on MRSA and C-Diff). The education section of the Patient Profile will be used to document this teaching.

PATIENT INSTRUCTIONS:

The surgeon will provide written instructions for the patient at the time of the preoperative work-up appointment. The instructions describe the pre operative work-up, admission, and recovery periods. The surgeon or office staff must explain and emphasize the importance of the following instructions:

Before Operation:

- The patient should be told not to eat food after midnight but may have clear fluids only (water, Gatorade, Crystal Light, or bowel prep) up to 2 hours prior to surgery as instructed by the surgeon.

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- If patient has eaten within 8 hours of the surgery the anesthesia provider and surgeon must be notified. Refer to the NPO Guidelines for children and infants schedule and the "Enhanced Recovery After Surgery" guidelines.
- Notify the surgeon of any change in physical condition (cold, fever, etc.).
- If patient feels uncomfortable with impending surgical procedure or has questions regarding the surgery or anesthesia the surgeon and anesthesia provider should be notified before proceeding with procedure.
- The patient must have had a complete history and physical examination, and appropriate lab work done. These reports must be on the chart available for the anesthesia provider. Additional laboratory tests, CXR, EKG or other tests, may be needed on the basis of age and physical status as requested by the physician.
- Patients for a 0730 surgery should be at the hospital for admission at 0600 the morning of surgery, or 1 ½ hours prior to the anticipated time of surgery if case is scheduled later. Scheduled (AM admits) C-sections will have a stress test done in the Perinatal Unit then be prepared for surgery in the Preoperative Unit (see above).

After Operation Instructions for patients:

- **Arrange for responsible adult to accompany you home.**
- You will not be allowed to drive for 24 hours.
- You should not ingest alcoholic beverages of take medication not specifically prescribed.
- Important decision making should be delayed until complete recovery has been made.

PROCEDURE: (Also see the policy/procedure "Preoperative Interview")

A. **Preoperative Interview**

All scheduled surgical patients shall have a pre-operative interview prior to the day of surgery. Patients that have not had a preoperative interview done in person will be phoned the weekday before their scheduled surgery for an interview. Patients requiring an urgent (unscheduled) surgery will have preoperative teaching completed by the nurse on the unit to which he/she has been admitted. If the surgery is an emergency*, the preoperative interview will not be conducted and "Emergency Surgery" should be written in the upper section of the Surgical Checklist. All preoperative teaching shall be documented in the electronic health record. If paper forms are to be used; the top of the Surgical Checklist, and the Nursing Assessment form (through the social services section) should be completed. A short assessment form may be used for cataract and colonoscopy patients (this can be found on the back of the Surgical Checklist). The perioperative nurses are responsible for the preoperative interview for elective surgeries.

* Emergency: a patient condition, which requires immediate treatment and is necessary to prevent patient death, severe disability or deterioration or aggravation of the patient's condition

Preoperative teaching should include the following:

- o Determine the patient's level of knowledge regarding his/her surgery. Any questionable aspect of the pre-op teaching should be discussed with the surgeon.

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- Using the "Preoperative Medication Guidelines" policy, current medications and allergies are reviewed with the patient, including history of allergy to suture and iodine products. The patient will be instructed to "hold" certain medications according to the "Preoperative Medication Guidelines" policy. The anesthesia provider may also be contacted to provide instructions for medication use preoperatively if needed.

- Description of the preoperative process; inform the patient that the anesthesia provider will visit prior to surgery to discuss all aspects of anesthesia. If the anesthesia provider has already spoken with the patient, reinforce the anesthesia provider teaching. The OR environment (lights, monitors, positioning, approximate operating room time) should be described as well as the PACU environment (oxygen, monitors, approximate PACU time). Review visiting information which includes: the surgeon will talk to family following surgery, PACU visitors, routine visiting hours (for inpatients).

- Reinforce the importance of deep breathing and coughing and the use of the incentive spirometer, and splint pillow if indicated. Discuss the importance of movement in bed (i.e. improve circulation / prevent venous stasis, etc.) and early ambulation. Describe drains/tubes/catheters if applicable.

- Discuss the importance of asking for pain medication to decrease pain so he/she will be able to complete above with minimal discomfort.

- The patient must have arrangements for a responsible adult to take him/her home and stay with patient overnight as directed by the surgeon. The patient will not be allowed to drive for twenty four hours after anesthesia. Important decision making should be delayed until 24 hrs. after general anesthetic or procedural sedation. The patient should not drink alcoholic beverages or take medications not specifically prescribed by physician.

B. **Patient Care Plan –** If documenting electronically, a surgical care plan should be completed in the electronic health record. If using a paper form, the care plan can be found in the middle of the Surgical Checklist**:** If a patient has any problems or potential problems not addressed in these standard care plans; the problem and plan of care should be outlined. If there are no problems other than those addressed by the generic operative care plan and the care plan for that particular surgery, "standards of care for procedure" should be written in the care plan section.

C. **The Chart-Day Before Surgery**

- The chart will be put together by the PACU clerk the day before surgery. Documents include history and physical, lab, EKG and X-ray reports, doctors' orders, etc.
- The outpatient nurse will review the charts the day before the surgery screening lab, x-ray, and EKG reports and notify the surgeon and/or anesthesia provider of any abnormal values.

D. **Surgical Checklist**

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Title: Preoperative Preparation and Teaching	
Scope: PACU, Surgery	Manual: CPM - Communication (COM)
Source: DON Perioperative Services	Effective Date: 12/2013

- **The Surgical Checklist** must be filled out completely, all blanks must be filled in; use of N/A (not applicable) as necessary.

- Completion of surgical checklists for inpatients are the responsibility of the RN caring for that patient on that particular unit (on the shift that the patient is sent to the OR); Outpatient and AM admit checklists will be completed by the Preoperative staff.

E. **Nursing Assessment -** Completed including vital signs, etc.

F. **Informed consent** - The consent shall be written as per physician's order completely and without abbreviations. When appropriate, must include right or left (as in right leg, left eye, etc.).
- Special consents are needed for transfusion, sterilization, hysterectomy, photography, observation and breast cancer therapy.
- In emergency situations involving a minor, unconscious or incompetent patient the situation is to be fully explained on the medical record with confirmation by a second physician.

G. **Other Paperwork**
- Physician orders should be completed, noted and on chart.

- A copy of the patient's history & physical performed and recorded with 30 days of surgery. The history and physical is to be updated and signed by physician the morning of surgery for Outpatient procedures. For inpatient procedures, the history and physical does not have to be updated the morning of surgery. If the history and physical is older than 30 days it must be redone. The History and Physical must be available electronically or on the patient chart prior to the patient entering the operating room. Exception to this is for a life or limb threatening emergency.

- Results of ordered **laboratory work and tests** performed must be available electronically or on the chart prior to surgery. Laboratory values and test reports should be reviewed for normal values and abnormal values reported to the anesthesiologist and surgeon.

- In order to be certain that the right type of blood and sufficient quantity is available if needed for surgery; the patient should be typed and cross-matched 3 days prior to scheduled surgery.

- For elective procedures all women of childbearing potential (from the onset of menses until the woman has not had a menstrual cycle in over a year) with intact tubo/ovarian/uterine anatomy will have an HCG (pregnancy test) unless they refuse. A copy of these records may be an acceptable substitute if the patient had these studies done elsewhere.

- The operation shall be delayed until above are complete. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. If the history and physical have been dictated, but not transcribed, the surgeon shall so state in writing on the progress notes.

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- Patients whose procedures require local anesthesia involving a small area only may not require preoperative testing at the discretion of the operating surgeon.

- If ordered, the EKG should be in the chart. If no EKG ordered, pt shall have a three lead EKG monitor strip documented on chart. Do not place leads in the area of the surgical site (check with the circulating OR RN if unsure about lead placement).

Patient Prep
Dress:

- The patient will dressed in hospital attire: gown, hair cap and foot covers. The patient must have his/her identification bracelet on. All jewelry will be removed. If jewelry cannot be removed, it can be covered with tape. All valuables will be sent home or placed in a valuables envelope and placed in the safe. All makeup should be removed.

- Valuables will be given to the patient's significant other or stored in the safe. Clothing will be put in labeled plastic bags and taken to the PACU (outpatients) or the patient's room (inpatients).

- The removal of prosthetic devices such as eye glasses, hearing aids and dentures are to be moderated by good nursing judgment in consultation with the anesthesiologist. (Example, a patient who is deaf could come to the OR with a hearing aid in place if the anesthesiologist was notified). Once removed, document location of devices jewelry, clothing, luggage, etc. on the surgical checklist and the assessment sheet.

Surgical Site Prep and Marking:

Preoperative prep will be performed routinely by the preoperative staff per physician's order.

After confirming appropriate surgical site/side, the SURGEON will mark the surgical site with his initials, designating correct site/side using a one-time use pen. Ophthalmology patients will have a colored dot placed above the operative eye. The ophthalmologist will place his initials over the patient's eyebrow of the eye to be operated on, again using the disposable pen.
If there is any discrepancy between the surgical procedure scheduled, Surgical Consent, Physician History and Physical documentation of the site or side, or the patient's understanding of the procedure/site or side, they must be clarified between the surgeon and the patient before the site/side is marked and the patient is transported to the operating room. Documentation of surgical site verification will be noted on the Surgical Checklist, the Surgical Safety Checklist and Intraoperative Record.

IV Tubing and Solution:

The patient's IV should have anesthesia tubing (gravity tubing without a filter) and a luer lock extension. Check the physician's order for solution and rate.

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If there is a written/verbal order for changing the IV Solution/Tubing, this should be changed prior to the patient coming to the operating room/holding room. If there is no order, the patient will be sent to the Operating Room/Holding Room with the current IV solution/tubing hanging and they will be changed by the anesthesia provider caring for the patient. This procedure should be completed on all in-house patients scheduled for surgery since frequently there are schedule add-ons, changes and switches.

Transfer to OR

The surgery staff will notify the unit when they are ready for the patient. The patient will be transferred to the OR by the unit staff, appropriately prepped and dressed with their completed medical record. The patient will be transported by gurney, side rails up.

Patients with a fractured hip or in traction will be transported in their unit bed with traction devices in place.
Small children may be carried to the OR by a parent upon the anesthesia provider's request. (See policy/procedure on Transfer of Patients to the O. R.)

Patients must have O_2 during transport if continuous O_2 has been ordered by the attending physician.

C-SECTIONS

C-Section patients will be told to arrive @ 0530, check in at ED registration desk and report to the Perinatal Unit. The perinatal RN will complete an NST on the patient for fetal well-being. The Family Caregiver (support person) will receive scrubs to change into and will accompany the patient to the PACU no later than 0615. The patient will be assessed and prepped for surgery in the preoperative unit (patient gown on, height, weight, vital signs, IV, etc). The patient should be ready to be taken to the OR by 0730.

If for some reason there is an issue getting the passing NST or the patient arrives late to the hospital, the PACU staff should be notified so the patient preparation can be expedited. Factors to consider:

- There must be 2 staff members in the perinatal unit when patients are present. (Depending on acuity in the unit, staff from other units could come during that time to be the second staff member)
- If needed the portable monitor can be taken to PACU to complete the NST
- A PACU RN can come to the Perinatal Unit to begin prep work in conjunction with the Perinatal staff

A surgery chart will be assembled by the PACU clerk. The OB MD will have sent the H&P to the PACU clerk along with admit orders and a Perinatal summary sheet when the C-section was scheduled. Anesthesia forms will be added to the surgery chart by the PACU clerk.

DOCUMENTATION:

- Doctor's orders (noted by the RN)
- A Surgical checklist will be completed
- Appropriate consents will be signed (and witnessed)
- Electronic assessment and care plan completed
- Medication reconciliation form (outpatients only) completed and placed in chart with H&P for the physician to complete

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Preoperative Preparation and Teaching	
Scope: PACU, Surgery	Manual: CPM - Communication (COM)
Source: DON Perioperative Services	Effective Date: 12/2013

REFERENCES:
1. ASPAN 2012-2014 Perianesthesia Nursing (Standards, Practice Recommendations, and Interpretive Standards)

CROSS REFERENCE P&P:
1. Preoperative Interview
2. NPO Guidelines
3. NPO Guideline Table for children
4. Preoperative EPT testing protocol
5. Skin Preparation in the Perioperative Unit
6. Patient Visitation Rights
7. Preoperative Medication Guidelines

Approval	**Date**
CCOC	11/20/17
STTA	01/24/18
MEC	05/07/18
Board of Directors	
Last Board of Director review	1/18/17

Developed: 11/2013
Reviewed: 2/15
Revised: 12/16, 1/17aw, 2/18aw, 4/18aw
Supersedes:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Care PACU	
Scope: PACU	Manual: Anesthesia, PACU
Source: DON Perioperative Services	Effective Date:

1. Throughout their stay, patients will receive nursing care based on an assessment of their needs. Each patient will be assessed on admission by an RN. The patient's condition shall be evaluated continually in the PACU.
   A. All patients undergoing operative, manipulative or diagnostic procedures under general or regional anesthesia, shall stay in the PACU before being returned to the nursing unit, except for those patients who, in the judgment of the surgeon and anesthesia provider, should be taken directly to an in-patient hospital room. At the conclusion of the surgery all patients who receive anesthesia care shall be admitted to the PACU or equivalent (ICU or nursing unit as dictated by the patient's condition and care requirements) by specific order of the anesthesia provider responsible for the patient's care. The anesthesia provider, surgeon or responsible physician shall ascertain the patient is in satisfactory condition before delegating the immediate care to the PACU nurse.
   B. A patient transported to the PACU shall be accompanied by a member of the anesthesia care team or surgeon who is knowledgeable about the patient's condition. The patient shall be evaluated and treated during transport with monitoring and support appropriate to the patient's condition. In the PACU patient is under the direct observation and care of the PACU nurse who works under the medical direction of the Anesthesiology Service.
   C. Upon arrival in the PACU the patient shall be evaluated and a verbal report provided to the responsible PACU nurse by the member of the anesthesia care team who accompanies the patient. The report should include: pre-existing medical problems, anesthetic technique used, surgery or procedure performed, any untoward reactions or unusual incidents, special orders or precautions, oxygen therapy and analgesia.
   D. The PACU nurse will use data from the preoperative assessment, surgical checklist, care plan and information from the anesthesiologist's report and sheet, the OR sheet and the circulating nurses report for the PACU assessment.
   E. The responsible physician shall be notified immediately of any deterioration in the patient's condition, including by not limited to: tachycardia, bradycardia, cardiac arrhythmias, hypotension, hemorrhage, convulsions, hyperpyrexia, respiratory distress or cyanosis.The responsibility for patients in the PACU is a joint one, shared by the surgeon and the anesthesia provider. Requests for assistance by the PACU personnel shall evoke immediate and appropriate response on the part of physicians involved.

2. The patient's care will be planned, written, individualized, and updated as needed. The care will be coordinated with other health team members and will involve the patient and family as appropriate.
   A. Following the **Nursing Care Guidelines in the PACU**, the PACU nurse will assess and maintain ventilation, hemostasis and circulation of the patient. The PACU nurse will assess level of consciousness and promote reactivity, assess and promote fluid and electrolyte balance.
   B. Information from the assessment will be incorporated into the PACU care plan, in the PACU record.
   C. Post-operative orders are to be written when the patient's care is transferred to the PACU nurse, except when extreme emergency requires the presence of the physician in another area.
   D. Following the **Nursing Care Guidelines in the PACU**, the PACU nurse will provide for assistance with emotional and spiritual needs and promote the comfort of the postoperative patient.
   E. The PACU in not to be used as a substitute for routine post-operative care and patients requiring prolonged observations of care should be admitted or transferred to 23 hour observation status.
   F. If no anesthesiologist is involved in the care of the patient, the surgeon or responsible physician shall perform those duties in the PACU for which the anesthesiologist would normally be responsible.
   G. All visits to the PACU by the surgeon, anesthesiologist or responsible physician shall be recorded in the PACU record.

Draft

Title: Standards of Care PACU	
Scope: PACU	Manual: Anesthesia, PACU
Source: DON Perioperative Services	Effective Date:

3. A safe, clean environment shall be provided for all patients, staff and visitors. Universal Precautions will be followed at all times.
   A. The PACU staff will wear clean scrub attire.
   B. The PACU will be cleaned daily, equipment will be cleaned appropriately after patient discharge and/or at the end of the day.
   C. Following PACU Patient Care Guidelines, the safety of the postoperative patient will be ensured by the use of siderails and brakes on gurney or bed. Outpatients will be discharged by private wheelchair or ambulatory if the patient prefers and the patient has had only a local anesthetic.
   D. Patients in Contact Precautions and Respiratory Isolation will be recovered in an infection control room following appropriate standards, having all supplies and resuscitative equipment readily available and following all infection control policies.

4. All nursing care will be appropriately documented.
   A. The patient's level of consciousness and vital signs will be recorded in the PACU record on entering and leaving the PACU. Intravenous fluids, medications, blood and blood product administration will be documented
   B. Teaching, nursing care, medications given and disposition of belongings will be documented in the PACU record. Patient information will be logged in the PACU log book.
   C. All unusual incidents and untoward reactions shall be recorded in the PACU record.
   D. Any significant problem or change in status of the PACU patient will be reported to the anesthesiologist and/or surgeon.
   E. When a patient is transferred to another facility, moved to another area of the hospital, or discharged, their status will be documented in the medical record and by verbal report.

5. All medications will be given appropriately and according to hospital policy; including the right patient, right medication , right dose, right time and right route.
   A. After the preoperative checklist, OR record and anesthesia record have been checked for medications given, the PACU nurse will give medications ordered by the anesthesia provider. Medication ordered by the surgeon will be given with the anesthesia provider's approval. The pharmacy will be kept apprised of medications given in OR and PACU so that medications ordered for the inpatients can be coordinated with receiving unit.

6. Confidentiality and personal privacy will be maintained for patients at all times.
   A. Depending on the number of patients in the PACU, their status and privacy needs, visiting will be allowed in PACU at the PACU nurses discretion.
   B. Curtains will be used to provide privacy as the patients status warrants, (the PACU nurse must be able to see the patients at all times).

7. Discharge planning shall be initiated for all patients as soon as possible, necessary referrals made on a timely basis, and appropriate documentation made on the medical record.
   A. The decision for outpatient discharge from the PACU is made by a physician. The medical record shall reflect which physician was responsible for the patient's release.
   B. PACU discharge criteria must be met for PACU discharge unless otherwise determined by the anesthesia provider or the surgeon.
   C. The PACU nurse will review the discharge instructions with the patient and the responsible adult taking the patient home.

Draft

Title: Standards of Care PACU	
Scope: PACU	Manual: Anesthesia, PACU
Source: DON Perioperative Services	Effective Date:

D. Any patient that has received an anesthetic or IV sedation must be taken home by a responsible adult (excepting cases with use of local anesthetic only).
E. The inpatient may be discharged from the PACU utilizing the discharge criteria approved by the Surgery-Tissue Committee
F. The PACU nurse will call the receiving unit with an estimated time of PACU discharge and need for special equipment. Following the PACU Patient Care Guidelines, verbal report will be given to the receiving unit nurse.
G. Inpatients will be transported to the hospital unit in a manner that maintains: safety (IV lines, tubes, drains and oxygen tubing should be secured, side-rails should be up, a PACU RN and another staff member should transport the patient, privacy (patient / staff elevator should be used, patient should be appropriately covered), and comfort (explain transport to patient, transport feet first and avoid rapid movement).

8. Throughout the patient's stay, the patient and, as appropriate, his significant other will receive education specific to the patient's health care needs.
   A. The PACU nurse will coordinate outpatient discharge with the pharmacy (for prescriptions) and other facilities for special equipment/home health care as needed. Follow up appointments will be made for the patient as requested and appointment times documented as well as contact number and name of the physician to be called for problems. All valuables/belongings will be returned to the patient prior to discharge.
   B. The PACU nurse will review the doctor's written discharge instructions with the patient and the responsible adult with the patient. Signatures will be obtained from the patient and or the responsible adult with the patient and a copy of the instructions will be given to the patient. The PACU nurse will allow time for questions and equipment use demonstration.
   C. Pictures, brochures, additional information sheets, dressing change supplies, ice packs, and special equipment will be sent home with the patient as applicable.

REFERENCE:

1. TJC PC: 03.01.07, TJC PC: 04.01.03
2. *American Society of Perianesthesia Nursing Standards, 2012-2014*

CROSS REFERENCE P&P:

1. Nursing Care Guidelines in the PACU, Anesthesia Clinical Standards and Professional Conduct,

Approval	**Date**
CCOC	1/29/18
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Board of Directors	
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Revised: 5/94, 12/17aw
Index Listings: Standards of Care, PACU; PACU Standards of Care; Care Standards, PACU
Supersedes: Post Anesthesia Recovery

draft

Surgical Critical Indicators

2018

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

Approvals:

Surgery/Tissue/Transfusion/Anesthesia: 4/25/18
Medical Executive Committee: 5/7/18
Board of Directors:

Anesthesia Critical Indicators

2018

Adopted from 'MACRA Ready' Adverse Events Reporting Form

Cardiovascular

1. Dysrythmia requiring intervention
2. Cardiac arrest (unplanned)
3. Unexpected death
4. Stroke, CVA, or coma
5. Myocardial ischemia
6. Myocardial infarction
7. Vascular access injury (arterial/pneumothorax)
8. Uncontrolled HTN

Respiratory

9. Aspiration
10. Pneumothorax (related to anesthesia)

Regional

11. Failed Regional Anesthetic
12. Systemic local anesthetic toxicity
13. Post-dural puncture headache
14. Epidural hematoma after spinal/epidural
15. Epidural abscess after spinal/epidural
16. Peripheral nerve injury following regional
17. Infection following peripheral nerve block

PACU

18. Temperature <95.9° F or <35.5° C
19. Inadequate Reversal
20. Reintubation (planned trial extubation documented)
21. Reintubation (no planned trial extubation)

Medication

22. Medication administration error
23. Adverse transfusion reaction
24. Anaphylaxis

Process

25. Wrong site surgery
26. Wrong patient
27. Difficult airway
28. Unplanned hospital admission
29. Unplanned ICU admission
30. Wrong surgical procedure

Miscellaneous

31. Dental trauma
32. Visual loss
33. Malignant Hypothermia
34. Awareness under GA
35. Equipment malfunction
36. Fire in OR
37. Airway fire in OR
38. Corneal abrasion
39. Fall in OR
40. Other

Approvals:

Surgery/Tissue/Transfusion/Anesthesia: 4/25/18
Medical Executive Committee: 5/7/18
Board of Directors:

Perinatal Critical Indicators

2018

1. Maternal death or resuscitation
2. Fetal demise beyond 20 weeks gestation
3. Transfer to a higher level of care
4. Apgar score below 7 at 5 minutes
5. Neonatal trauma
6. Maternal seizure
7. Vaginal deliveries coded with shoulder dystocia
8. 3rd and 4th degree lacerations
9. Postpartum hemorrhage requiring transfusion (blood loss greater than 500 ml for vaginal delivery; blood loss greater than 1,000 ml for cesarean section)
10. Postpartum readmission
11. Disruption or infection of obstetrical wound
12. Delivery of infant less than 36 weeks gestation
13. Maternal admission to ICU
14. Maternal induction of labor less than 39 weeks without documented indication

Approvals:

Peri-Peds Committee: 4/20/2018
Medical Executive Committee: 5/7/2018
Board of Directors:

Neonatal Critical Indicators

2018

1. Apgar score 6 or less at 1 or 5 minutes
2. Neonatal resuscitation (PPV or beyond)
3. Infant in Neonatal Peds status
4. Birthweight less than 2000g
5. Infant of a diabetic mother
6. Gestation less than 36 weeks
7. Infant re-admitted within 48 hours of discharge
8. Transfer to NICU
9. Pediatrician attended delivery
10. Any chart brought forward by a RN due to concerns

Approved:

Peri-Peds Committee: 4/20/2018
Medical Executive Committee: 5/7/2018
Board of Directors:

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

OBSTETRICS & GYNECOLOGY

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

INITIAL CRITERIA

Education/Formal Training:
- Completed accredited residency training in Obstetrics and Gynecology.
- Board Certified/Board Eligible by the American Board of Obstetrics and Gynecology or equivalent.
- All practitioners requesting privileges to manage and attend births in Labor and Deliver at Northern Inyo Hospital will complete the appropriate BETA (Quest for Zero: Excellence in OB) requirements and will comply with NICHD terminology in the OB setting.

INPATIENT CORE PRIVILEGES

Request	
☐	• Admit, evaluate, diagnose, consult, perform H&P, and manage the care of female patients in any condition or stage of pregnancy who present to the hospital or Emergency Department. • Admit, evaluate, diagnose, consult, perform H&P, and provide pre-operative, intra-operative and post-operative care for management of female patients presenting with illness, injury, disorders of the gynecologic or genitourinary system. • Vaginal delivery • Hysterectomy • Cesarean section • Cesarean hysterectomy • Diagnostic cystoscopy • Diagnostic and operative hysteroscopy • Diagnostic and operative laparoscopy • Diagnostic and operative laparotomy • Adnexal surgery • Ultrasound • Suburethral slings

OUTPATIENT CORE PRIVILEGES

Request	
☐	• Assess, evaluate, diagnose, consult, perform H&P, and manage the care of female patients in any condition or stage of pregnancy or with illness, injury, or disorders of the gynecologic or genitourinary system who present to the outpatient clinic.

SPECIAL PRIVILEGES

☐ Circumcision with clamp, pediatric only ☐ Robotics (see separate list)	☐ Insertion/removal of implanted contraceptive device (e.g. Nexplanon) ☐ Cervical cerclage

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 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 Obstetrics *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)